Arizona Medical Board

9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258
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FINAL MINUTES FOR REGULAR SESSION MEETING
Held at 9:00 a.m. on April 5, 2006, and 8:00 a.m. on April 6, 2006, 9535 E. Doubletree Ranch Road · Scottsdale, Arizona

Board Members

Robert P. Goldfarb, M.D., FACS, Chair
William R. Martin III, M.D., Vice Chair
Douglas D. Lee, M.D., Secretary
Patrick N. Connell, M.D.
Patricia R.J. Griffen
Tim. B. Hunter, M.D.
Becky Jordan
Ram R. Krishna, M.D.
Lorraine L. Mackstaller, M.D.
Sharon B. Megdal, Ph.D.
Dona Pardo, Ph.D., R.N.
Paul M. Petelin Sr., M.D.

WEDNESDAY, April 5, 2006

CALL TO ORDER
Robert P. Goldfarb, M.D. called the meeting to order at 9:00 a.m.

ROLL CALL
The following Board Members were present: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., and Paul M. Petelin, Sr., M.D.

CALL TO THE PUBLIC
Statements issued during the Call to the Public appear beneath the case referenced.

Executive Director's Report

Approval of Criteria for Choosing Board Evaluation Treatment Programs
Timothy Miller, J.D., Executive Director asked the Board to accept the proposed criteria for choosing a program and allow Staff to choose programs accordingly.
MOTION: Patrick N. Connell, M.D. moved to approve the criteria for choosing Board Evaluation Treatment Programs.
SECONDED: Paul M. Petelin, M.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

Pain Management Guidelines
Mr. Miller submitted the draft of the Pain Management Guidelines for the Board's approval. Mr. Miller informed the Board the Guidelines were presented to the public at the Pain Management Guideline Stakeholder's Meeting and were well received.

Dr. Connell said the Guidelines appeared well written for chronic pain, but they did not address acute pain. Mr. Miller said the Guidelines were not meant to address acute pain because the community asked for guidance for the treatment of chronic pain. Sharon B. Megdal, Ph.D. suggested the word "chronic" be inserted in the title of the Guidelines.

Christine Cassetta, Board Legal Counsel noted an edit. Ms. Cassetta said the preamble, second paragraph, last sentence read "The Board judges the validity of the physician's treatment of the patient based on the outcome of the investigation". Ms. Cassetta recommended it be edited to say "The Board judges the validity of the physician's treatment of the patient based on all the information, not just the quantity and duration of the medication administration."
MOTION: Ram R. Krishna, M.D. moved to adopt the Pain Management Guidelines per the edits mentioned above.
SECONDED: Tim B. Hunter, M.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

Licensing Application Rule Change & License Application

Mr. Miller said the current license application questions are not as efficiently worded as they should be in that some information is requested and obtained from applicants that is not used by the Board. Mr. Miller said that in order to change the application, the licensing application rule has to be changed. Christine Cassetta, Board Legal Counsel informed the Board the new Rule would simply state that an applicant must fill out the application available at the Board's offices (with the Board's address listed) or on www.azmd.gov. This change would allow the Board greater flexibility in changing the questions as the need arises or as suggested by the Federation of State Medical Boards. Ms. Cassetta also asked the Board to authorize Mr. Miller to change the questions as needed without prior Board approval. Ms. Cassetta noted the Board would be informed of any changes at the first Board meeting after any change was made. Ms. Cassetta thanked Suzann Grabe, Licensing Manager, for making sure there were regular meetings to get the new questions written. Dr. Goldfarb noted the new questions were very good.

MOTION: Tim B. Hunter, M.D. moved to open the docket, approve of the application questions and give the Executive Director the authority to change the questions as needed and to present the changes to the Board for approval at the first Board meeting after any change is made.
SECONDED: Ram R. Krishna, M.D.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

Performance Indicators

Mr. Miller updated the Board on the Agency's performance indicators. Mr. Miller said that over the past year Staff has done a tremendous job in completing 2,072 investigations, leaving only 588 open cases. Mr. Miller said the case load had been reduced by 54% since April 1, 2005. He also said, over the past two months, Staff has been able to meet the goal of completing investigations within 180 days. Mr. Miller said all of the Staff's progress had been accomplished without sacrificing the quality of the investigations. Patrick N. Connell, M.D. noted he noticed the quality of the investigations had significantly improved, and he commended Staff. Tim B. Hunter, M.D. said he noticed the quality of the Staff Investigational Review Committee (SIRC) reports had significantly improved and he also commended Staff. Robert P. Goldfarb, M.D. commended the Agency's medical consultants also for the way in which they evaluate the quality of care issues in the cases.

Legislation Report

Mr. Miller summarized some of the highlighted bills of interest for the Board.

House Bill 2413- This Bill died. This Bill involved a new complaint process for judicially appointed health professionals.
Senate Bill 1102 – This Bill pertains to the posting of pending physician complaints/allegations on the internet. Mr. Miller said that if this Bill passes open investigations would not be on the physician's profile and would not be public record.
House Bill 2240- This Bill has failed, but there has been a motion for reconsideration. This Bill was to ensure that state agencies were not imposing fees that were higher than their operating budgets.
House Bill 2426- This Bill had been amended to make it an act of unprofessional conduct for a physician to direct a laboratory that conducted a test at the health professional's orders to submit the bill to the health professional. This Bill would prevent inappropriate charging for laboratory fees to patients from physicians.
House Bill 2786- This Bill requires the appropriate regulatory board to assume responsibility for abandoned patient medical records of licensees and to be responsible for redirection of the records. Mr. Miller said this Bill would add a large amount of work to the Board if passed, and did not allow a way for appropriation of funds to handle the additional work load.
Senate Bill 1084- This is the Arizona Medical Board Omnibus Bill and it is on its way to the House.
Senate Bill 1341- This Bill would allow regulatory boards to treat a class 6 felony as a misdemeanor if the court designates the felony as a misdemeanor.

Patrick N. Connell, M.D. said the emergency care physicians were heading Senate Bill 1351. The bill, if passed, would require that in a malpractice situation, clear and convincing evidence would be required in order to make a judgment, rather than a preponderance of evidence. The new law would only pertain to physicians who provide services under the Federal Emergency Medical Treatment and Active Labor Act (EMTALA) laws.

Legal Advisor Report

Christine Cassetta, Board Legal Counsel brought to the Board's attention a pharmacy board case. She said the Medical Board reprimanded Dr. Golob for internet prescribing and, after the Board took action against Dr. Golob, The Arizona State Board of Pharmacy instituted proceedings against the pharmacy connected with Dr. Golob's prescribing. Ms. Cassetta said there was a Formal Hearing and the Administrative Law Judged (ALJ) cited many of the Medical Board's Findings of Fact. Ms. Cassetta said the ALJ found it was unprofessional conduct to prescribe over the internet and the pharmacy involved should be disciplined by the Pharmacy Board. Ms. Cassetta noted Dr. Kelly Sems testified as an expert for the State and did an excellent job.

Approval of Minutes

January 30, 2006 Summary Action Meeting Minutes
February 8-9, 2006 Regular Session Minutes, *including* Executive Session Minutes
February 21, 2006 Summary Action Meeting Minutes

MOTION: Dona Pardo, R.N., Ph.D. moved approved the January 30, 2006 Summary Action Meeting Minutes, the February 8-9, 2006 Regular Session Minutes, including Executive Session Minutes, and the February 21, 2006 Summary Action Meeting Minutes.
SECONDED: Becky Jordan
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

ADVISORY LETTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-1252A	S.S.	DONALD J. BOLES, M.D.	17193	Advisory Letter for failure to document a complex physical examination and for inappropriate billing.
2.	MD-05-0211A	M.H.	VINCENT P. CARIATI, M.D.	20889	Advisory Letter for failure to correctly interpret lab results.
3.	MD-04-0913A MD-04-0918A	R.O. D.D.	JEFFREY S. LEVINE, M.D.	20383	Advisory Letter for failure to provide x-rays to a patient resulting in unnecessary exposure to subsequent x-rays.

Jeffrey Levine, M.D. was present and spoke during the call to the public. He said he believed this was a Child Protective Service (CPS) case in which the father allegedly broke the child's ankle. He said the father did not present with the child immediately after the fracture, did not bring the patient's original x-rays when he presented, and did not have an insurance plan. Dr. Levine said he performed an x-ray for the patient at no cost. The x-ray showed the patient had a displaced fracture, and Dr. Levine said since he does not perform operative interventions, he referred the patient for further care. Dr. Levine said he offered copies of the x-rays he performed to the father, but did not give the original x-rays because of the allegation that the father caused the child's injury.

Gerald Moczynski, M.D., Medical Consultant summarized the case: Dr. Levine said the only solution for this patient was an operative solution, however a following physician treated the patient with a cast and it healed correctly. Dr. Moczynski found Dr. Levine did not present a non-surgical option to the patient. Dr. Moczynski also said Dr. Levine did not make the patient's x-rays he performed immediately available to the father, as Dr. Levine's office notes show copies could be provided either in a couple hours or the next day. However, because of the surgical option presented to the father, the father felt he should seek care quickly, rather than waiting for the x-rays. The father took the child to the Emergency Room where additional x-rays were obtained. Dr. Moczynski said it would not have been necessary to subject the child to subsequent x-rays if Dr. Levine had immediately provided copies to the father. Dr. Moczynski also noted it was Dr. Levine's testimony that when the Emergency Room physician called him about the patient's x-rays, he told the emergency room (ER) doctor of his findings. Dr. Moczynski said it was later determined by CPS that this was not a child abuse case, but even if abuse was in question, Dr. Moczynski believes copies of the films should have still been given to the father.

MOTION: Lorraine Mackstaller, M.D. moved to issue an Advisory Letter for failure to provide x-rays to a patient resulting in unnecessary exposure to subsequent x-rays.
SECONDED: Patricia R.J. Griffen

Lorraine Mackstaller, M.D. said that by Dr. Levine performing an x-ray for the patient, he accepted responsibility for the patient. Christine Cassetta, Board Legal Counsel said if a patient requests an x-ray for the demonstrated purpose of obtaining continuing care, the physician must provide the x-ray or other medical record..

VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-04-0776A	AMB	DOUGLAS G. LOWELL, M.D.	19871	Invite the physician for a Formal Interview.

Robert P. Goldfarb, M.D. said he knows Dr. Lowell but it will not affect his ability to adjudicate the case.

Paul M. Petelin, Sr., M.D. pulled this case for discussion. William Wolf, M.D., Medical Consultant summarized the case for the Board: the case came to Board as result of malpractice settlement alleging the patient with a neck mass should have had an upper neck or upper chest computed tomography (CT) scan or thyroid scan prior to surgery.

Dr. Petelin said he felt this to be a significant deviation of wrong site surgery because the patient had an unnecessary thoracotomy.

MOTION: Paul M. Petelin, Sr., M.D. moved to invite physician for Formal Interview.
SECONDED: Patrick N. Connell, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-05-0122A	AMB	VICTOR TSENG, M.D.	11655	Advisory Letter for failure to visualize the radial nerve.
6.	MD-05-0061A	AMB	VANCE SANDERS, M.D.	19792	Advisory Letter for inappropriate treatment and referral of a patient with SCFE.

Becky Jordan pulled this case for discussion.

Gerald Moczynski, M.D., Medical Consultant summarized the case for the Board: Vance Sanders, M.D. referred a 17-year-old with a slipped capital femoral epiphysis (SCFE) to an orthopedic physician without placing the patient on non-weight bearing status. He said the patient later had increased pain as a result of a fall following the appointment with Dr. Sanders. The patient had an unsuccessful surgery of his SCFE and went on to have a total hip arthroplasty.

Ram R. Krishna, M.D. said he did not find fault in the primary care physician, Dr. Sanders, for making the diagnosis of SCFE because this was an unusual case because the patient's age and body type was not typical of SCFE. This was a difficult diagnosis that a primary care physician is not usually expected to make. William R. Martin, III, M.D. agreed with Dr. Krishna, but also noted Dr. Sanders should have put the patient on

crutches until he was able to receive further care. Paul M. Petelin, Sr., M.D. noted the orthopedic physician who followed up with the patient did not see the patient until three weeks after the patient was referred and by that time the patient's condition had progressively worsened. Dr. Martin said since the patient was able to tolerate weight bearing following his visit with Dr. Sanders, it would seem the patient's displacement would have occurred at the time of the second fall.

William Wolf, M.D., Medical Consultant said the primary care physician usually would not be required to make a diagnosis of SCFE. Patrick N. Connell, M.D. said although Dr. Sanders may not have recognized the severity of the slip, he could have consulted with an orthopedic physician to get advice on how soon the patient should be seen. Dr. Wolf noted Dr. Sanders made a casual referral to the orthopedic physician without a sense of urgency.

MOTION: Tim B. Hunter, M.D. moved to Dismiss the case.
SECONDED: Paul M. Petelin, Sr., M.D.

Dr. Krishna and Dr. Martin spoke against the motion by saying, although it was exemplary that Dr. Sanders made the diagnosis, he did not take appropriate action by not putting the patient on crutches or expediting the referral.

VOTE: 4-yay, 7-nay, 1-abstain 0-recuse, 0-absent
MOTION FAILED.

MOTION: Patrick N. Connell, M.D. moved to issue an Advisory Letter for inappropriate treatment and referral of a patient with SCFE.
SECONDED: Ram R. Krishna, M.D.
VOTE: 8-yay, 3-nay,1-abstain 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-05-0187A	AMB	SUDHIR RANJAN, M.D.	13308	Advisory Letter for selection of inappropriate doses of drugs in the conduct of Anesthesia.

William R. Martin, III, M.D. recused himself from this case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-05-0252A	S.S.	ANGELO CHIRBAN, M.D.	27055	Advisory Letter for failure to recognize aberrant drug related behaviors and signs of substance abuse in a patient.
9.	MD-04-0640A	A.S.	SUSAN B. FLEMING, M.D.	14840	Advisory Letter for failure to address history of drug abuse and depression for a patient.
10.	MD-04-0959A	AMB	KENNETH L. SANDOCK, M.D.	14232	Advisory Letter for failure to order more specialized radiographic views for a breast lump.

Tim B. Hunter, M.D. recused himself from the case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-04-0564A	A.Z.	HELEN E. WATT, M.D.	22016	Advisory Letter for inadequate medical records to support the billing code of 99245.
12.	MD-04-1065A	J.C.	DAVID L. SIMMS, M.D.	18526	Dismiss

David Simms, M.D. was present and spoke during the call to the public. Dr. Sims said the patient was mistaken in her allegation that he biopsied her. He said he examined her with a scope that is not capable of biopsy. He responded to the allegation that he withheld the patient's medical records by stating that after his office sent a complete copy of the patient's medical records she alleged they were withholding information from her file. He said the patient again requested the records approximately five years later but by that time they had been purged.

Lorraine Mackstaller, M.D. pulled this case for discussion. Tina Geiser, Senior Medical Investigator summarized the case for the Board. She said the patient said she did not receive her complete medical record, but rather received only copies of correspondence from her file. However, the physician claims he provided a complete copy of the records. The file has since been purged according to the physician's testimony.

MOTION: Lorraine Mackstaller, M.D. moved to Dismiss the case.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 2-abstain 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
13.	MD-05-0093A	J.B.	ANDRE C. MATTHEWS, M.D.	12836	Advisory Letter for inadequate management of a wrist fracture.
14.	MD-05-1017A	AMB	LOUIS D. ROSENFIELD, M.D.	11475	Dismiss

Mr. Paul Giancola was present and spoke on behalf of Louis Rosenfield, M.D. during the call to the public. Has said Dr. Rosenfield has never practiced in Arizona and the incident in this case occurred over six years ago. A patient presented denying any trauma and was discharged after a five day stay in the hospital. While in the hospital, she complained of back pain. X-rays of the patient's chest, thoracic spine and cervical spine were reported as normal. The patient then complained of pain in her shoulders and arms, but a physical therapist saw her and noted no

findings. It was later found the patient's chest x-ray was misread and a bilateral fracture dislocation of shoulders had been missed. The patient first claimed the dislocation of her shoulder occurred while being lifted in the emergency room, but later changed her story and admitted to domestic violence. Mr. Giancola said a Cardiologist, such as Dr. Rosenfield, should not be expected to diagnose a dislocation of the shoulder.

This case was pulled for discussion. Gerald Moczynski, M.D., Medical Consultant summarized the case: The patient claimed her shoulders were injured when she was lifted in emergency room but later admitted to domestic violence. She was found to have significant fractures and dislocation, but this was not diagnosed by several physicians.

Tim B. Hunter, M.D. said he felt the physician was being unfairly treated because a number of people saw the patient and none diagnosed the shoulder dislocation. Dr. Hunter also agreed that a Cardiologist should not be responsible for a diagnosis of dislocated shoulder.

MOTION: Tim B. Hunter, M.D. moved to Dismiss the case.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

MOTION: Paul M. Petelin, Sr., M.D. moved to issue Advisory Letters for items 1,2,5,7,8,9,10,11 and 13.
SECONDED: Patricia R.J. Griffen
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

APPEAL OF ED DISMISSALS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-0455A	P.M.	MICHAEL J. CONWAY, M.D.	6878	Continue the case for further investigation by Board staff.

P.M. was present and spoke during the call to the public. She said she made it clear that she did not want to be observed by any students for her procedure, but she later learned students were present during her operation and a student also was brought to her beside post-operatively. P.M. stated that Dr. Conway informed her that the individual was a student. P.M. said she felt violated by Dr. Conway's disregard to her request. P.M. also said Dr. Conway said her surgical margins were clean when they were not.

Maricarmen Martinez, Senior Medical Investigator summarized the case for the Board: Staff's review of this case did not find any statutory violation. Staff found there was evidence of students present during the operation, per the medical records, however, although P.M. had valid reasons for refusing to have students present, and although Dr. Conway clearly violated her request, Dr. Conway did not violate the Medical Practice Act. Ms. Cassetta advised P.M.'s recourse may be a civil action.

MOTION: Patrick N. Connell, M.D. moved to uphold the Executive Director's Dismissal.
SECONDED: Becky Jordan

Tim B. Hunter, M.D. said it was clear the patient would not have gone ahead with the surgery if she knew her request would not be honored. Lorraine Mackstaller, M.D. said she felt a physician has to honor the patient's rights. Sharon B. Megdal, Ph.D. said this seemed to be a case of psychological harm and wondered if the Board could assume jurisdiction under that category.

Dean Brekke, Assistant Attorney General said this case did not involve a violation of the Medical Malpractice Act and therefore the Board did not have any jurisdiction to take an action against the physician in this case.

VOTE: 5-yay, 5-nay, 1-abstain/recuse, 1-absent
MOTION FAILED.

MOTION: Patrick N. Connell, M.D. to continue the case for further investigation by Board staff.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

OTHER BUSINESS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-04-0977A	B.P.	CRAIG A. BITTNER, M.D.	27982	Grant the Motion for Rehearing and Dismiss the case.

Dean Brekke, Assistant Attorney General said he initially advised the Board it had jurisdiction in this case because of Dr. Bittner's position as the company's medical director. Dr. Bittner did not personally render any services and there were multiple locations at which he employed others to perform the services. Mr. Brekke stated that after reviewing bankruptcy laws he learned the Board issued the disciplinary action without authority.

MOTION: Patrick N. Connell, M.D. moved to grant the Motion for Rehearing.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

Mr. Brekke advised the Board to dismiss the matter. Mr. Brekke said the Board did not have evidence the physician was using his license to charge a fee for services not rendered.

MOTION: Tim B. Hunter, M.D. moved to Dismiss the case.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 10-yay, 1-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-96-0532	AMB	JACK BERNDT, M.D.	24306	Grant the request for Termination of Probation.

Kathleen Muller, Physician Health Program Manager summarized the case by saying that on July 12, 1996 Jack Berndt, M.D. entered into a 5-year Order of Probation and an Indefinite Non-Disciplinary Rehabilitation Stipulation and Order. She said he successfully participated in the Board's program until he relocated out of state. She said he had since successfully completed the Nevada and Oregon Health Professional Program. David Greenberg, M.D., Board Addictionologist recommended termination of Dr. Berndt's Probation.

MOTION: William R. Martin, III, M.D. moved to grant the request for Termination of Probation.
SECONDED: Tim B. Hunter, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-02-0716A	AMB	MARK P. SALERNO, M.D.	25300	Grant Request for Modification of Board Order.

Kathleen Muller, Physician Health Program Manager summarized the case by saying Mark Salerno, M.D. has been compliant in submitting for drug screens for last two years. She said he requested termination of the portion of his agreement to submit for random drug screens because he had been compliant and because he was placed on Probation for concerns of mental health and not substance abuse.

MOTION: Ram R. Krishna, M.D. moved to grant the request for Modification of Board Order.
SECONDED: Tim B. Hunter, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-94-0149	ADHS	KEITH KING, M.D.	12299	Deny Request for Modification of Board Order.

Keith King, M.D. was present and spoke during the call to the public. He said he believe he was currently in a position to request the Board modify his practice restriction so he may serve in the rural community.

Sue Dana, Compliance Officer said Dr. King had remained compliant with his Board Order and was currently working in an administrative role reviewing files. She said Dr. King had obtained a letter from a chiropractor who was willing to supervise Dr. King if the Board granted him permission to return to the full practice of medicine.

Lorraine Mackstaller, M.D. noted Dr. King had complied with the practice restriction for the past 11 years and said she saw no evidence that the Board could deny granting full practice to Dr. King.

MOTION: Tim B. Hunter, M.D. moved to accept the request for Modification of Board Order.
SECONDED: Lorraine Mackstaller, M.D.

Patrick N. Connell, M.D. said Dr. King had not treated a patient in 11 years and he would be hesitant about letting Dr. King return to full practice without him undergoing a Physician Assessment and Clinical Education (PACE) evaluation. Dona Pardo, R.N., Ph.D. noted a chiropractor would not be qualified to oversee the practice of a medical physician. The Board instructed Ms. Dana to communicate their concerns to Dr. King and encourage him to resubmit his request for Modification of his Board Order once he could demonstrate competency.

MOTION: Patrick N. Connell, M.D. moved to deny the request for Modification of Board Order.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-03-0266A	AMB	ROBERT A. ROSENBERG, M.D.	22637	Accept Proposed Consent Agreement for a Decree of Censure and Probation for action taken against him by another licensing or regulatory jurisdiction for unprofessional conduct. Dr. Rosenberg is also placed on one year of probation. Dr. Rosenberg shall obtain 20 hours of Category I CME in Physician-Patient Ethics, a minimum 3-day course in Sexual Boundaries and a minimum 3-day course in Professional Boundaries.

MOTION: Ram R. Krishna, M.D. moved to accept the Proposed Consent Agreement for a Decree of Censure and Probation.
SECONDED: Sharon B. Megdal, Ph.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., and Paul M. Petelin, Sr., M.D. The following Board Member was absent: Douglas D. Lee, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-06-0094A	AMB	DALE W. STRUBLE, M.D.	34790	Accept the Consent Agreement for Surrender of Active License.

MOTION: Paul M. Petelin, M.D. moved to accept the Proposed Consent Agreement for Surrender of Active License.
SECONDED: William R. Martin, III, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., and Paul M. Petelin, Sr., M.D. The following Board Member was absent: Douglas D. Lee, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-05-0234A	AMB	MARION A. JABCZENSKI, M.D.	3812	Accept the Consent Agreement for Surrender of Active License.

MOTION: Ram R. Krishna, M.D. moved to Accept the Consent Agreement for Surrender of Active License.
SECONDED: Sharon B. Megdal, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-04-0427A	AMB	RICHARD P. GREENBERG, M.D.	13656	Accept the Consent Agreement for Letter of Reprimand for performing a wrong site surgery.
9.	MD-03-1116A	AMB	GARY L. LOWERY, M.D.	24907	Accept Proposed Consent Agreement for a Decree of Censure for inaccurate medical records, performing a medical procedure without proper privileges and qualifications, and incompetently performing surgery resulting in the death of a patient.
10.	MD-04-1314A	AMB	STUART MEDOFF, M.D.	12154	Accept Proposed Consent Agreement for a Letter of Reprimand for failure to hold a clear overview of H.G.'s care when test results showed a gradually enlarging mass that resulted in metastatic carcinoma and the death of H.G.

MOTION: Paul M. Petelin, M.D. moved to accept the Proposed Consent Agreements for items 8, 9, and 10.
SECONDED: William R. Martin, III, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., and Paul M. Petelin, Sr., M.D. The following Board Member was absent: Douglas D. Lee, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-03-1030A	AMB	SUDHIR GOEL, M.D.	27103	Accept Consent Agreement for a Decree of Censure for poor medical records and billing not supported by his medical records. Pay a civil penalty in the amount of $10,000.

Mark Nanney, M.D., Chief Medical Consultant summarized the case for the Board: Dr. Nanney said Sudhir Goel, M.D.'s medical notes appeared to be photocopied, with only the date changed for each patient and that he was not actually seeing patients. Brenda Heverly, Senior Medical Investigator said she compared 19 patient charts to Dr. Goel's billing ledger and found that 13 of the 19 charts did not have supporting medical records to substantiate the charges. The billing ledgers also revealed Dr. Goel was reimbursed by the insurance company for all services billed for 12 of the 13 patients.

MOTION: Patrick N. Connell, M.D. moved to accept the Consent Agreement for Decree of Censure and Civil Penalty.
SECONDED: Tim B. Hunter, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., and Paul M. Petelin, Sr., M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
12.	MD-04-0173A	AMB	SHAHID MALIK, M.D.	31690	Accept the Findings of Fact, Conclusions of Law and Order for Letter of Reprimand for prescribing controlled substances to a member of his immediate family and for failing to maintain an adequate medical record.
13.	MD-04-1504A	MICA	MAZEN H. KHAYATA, M.D.	20382	Accept the Findings of Fact, Conclusions of Law for a Letter of Reprimand for failure to properly evaluate a patient through critical imaging studies prior to embarking on a surgical procedure.
14.	MD-05-0214A	AMB	JOHN S. TRUITT, M.D.	21749	Accept the Findings of Fact, Conclusions of Law for Letter of Reprimand for inappropriately diagnosing recurrence of metastasis and treating the patient with radiation when lesions were benign.
15.	MD-05-0689A	AMB	STANFORD C. LEE, M.D.	30685	Accept the Findings of Fact, Conclusions of Law for Letter of Reprimand for prescribing controlled substances to a member of his immediate family.
16.	MD-04-0608A	AMB	JOEL COHEN, M.D.	8027	Accept the Findings of Fact, Conclusions of Law for a Letter of Reprimand for placing a dorsal graft instead of a strut graft, requiring the patient to undergo additional revision surgery and for maintaining an inadequate medical record.

MOTION: Patrick N. Connell, M.D. moved to accept the Findings of Fact, Conclusions of Law and Order for items 12,13,14,15, and 16.
SECONDED: Becky Jordan
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
17.	MD-05-0184A	AMB	RONALD S. SHERER, M.D.	19367	Continue the case and issue an Interim Order for a undergo a Physician Assessment and Clinical Education (PACE) Evaluation or other Board approved obstetric evaluation within 60 days at his own expense.

Ronald Sherer, M.D. was present with counsel Mr. Kent Turley and spoke during the call to the public. Dr. Sherer said he has performed 9,000 pregnancy deliveries while living in Phoenix for the past 15 years, during which time he had only one malpractice case. Dr. Sherer said it was not his practice to accept high-risk patients. He said when he considered the patient in this case to be out of his ability to control, he referred her to a perinatologist, but she did not follow his advice and subsequently returned to him and the fetus expired.

Aja Dao, Registered Nurse spoke on behalf of Dr. Sherer. She said she has worked with Dr. Sherer and knows him to be a passionate, caring physician. Galen Johnson, M.D. also spoke on behalf of Dr. Sherer during the call to the public saying Dr. Sherer's patients Dr. Sherer are very poor and that he did try to refer the patient to a specialist but she could not go due to finances.

Patrick N. Connell, M.D. noted Dr. Sherer had a significant prior board history. Sharon B. Megdal, Ph.D. said she felt it would be best to order a Physician Assessment and Clinical Education (PACE) evaluation and continue the case until the results of the evaluation were reviewed by the Board.

MOTION: Sharon B. Megdal, Ph.D. moved to continue the case and issue an Interim Order that he undergo a Physician Assessment and Clinical Evaluation (PACE) Evaluation or Board approved obstetric evaluation within 60 days at his own expense.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
18.	MD-04-1271A	AMB	BRADLEY A. SCHWARTZ, M.D.	26807	Deny the motion for rehearing and refer the case to the Office of Administrative Hearings with the understanding that the hearing will not be held until after the criminal trial is complete.

Robert P. Goldfarb, M.D. and Tim B. Hunter, M.D. recused themselves from the case.

Vicki Johansen, Senior Medical Investigator summarized the case and stated that Dr. Schwartz was arrested for his involvement in a murder for hire of his ex-partner. Ms. Johansen noted the Attorney General's Office will not schedule a hearing until the criminal trial is over. Dr. Schwartz remains under an interim practice restriction.

MOTION: Ram R. Krishna, M.D. moved to deny the appeal of the Executive Director's referral to formal hearing and refer the case to the Office of Administrative Hearings with the understanding that the hearing will not be held until after the criminal trial is complete.
SECONDED: Becky Jordan
VOTE: 9-yay, 0-nay, 0-abstain 2-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
19.	MD-04-0102A MD-05-0969A MD-05-1206A	AMB CSC AMB	WILLIAM E. MORA, M.D.	13088	Refer the case to Formal Hearing.

Victoria Kamm, Senior Medical Investigator summarized the three cases. The cases were reviewed by an Outside Medical Consultant (OMC) who found actual harm in that at least one patient suffered as a result of failed or incorrect surgical procedures and at least one patient had likely become addicted to narcotics as a result of over-prescribing by William Mora, M.D. It was also found that Dr. Mora's billing procedures were inappropriate.

MOTION: Tim B. Hunter, M.D. moved to refer the case to Formal Hearing.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
20.	MD-05-0257A MD-05-0275A	AMB C.D.	JUSTIN F. WEISS, M.D.	9418	Refer to Formal Hearing.

Robert P. Goldfarb, M.D. and Tim B. Hunter, M.D. recused themselves from this case.

Mr. Robert Kuhn, legal counsel, spoke on behalf of Justin Weiss, M.D. during the call to the public. Dr. Weiss' entity filed for bankruptcy, and appropriately followed the bankruptcy laws in relation to his patient records. He said the bankruptcy laws supersede the Arizona Medical Board statutes as the supreme law of the land.

Patricia Reynolds, Assistant Manager of Investigations summarized the case. She said it was unclear to her why Dr. Weiss' counsel spoke during the call to the public because both he and Dr. Weiss requested their case be referred to Formal Hearing. Ms. Reynolds said that when a request is made to refer a case to Formal Hearing the referral is automatic. Timothy Miller, J.D., Executive Director explained that usually this type of request would be automatically referred to Formal Hearing by the Executive Director, however, he said that it was his desire that a public record be made and preserved for this case in the way of discussion by the Arizona Medical Board in an open meeting. He said the physician was invited to a Formal Interview with the Board, but refused the invitation and asked for formal hearing.

MOTION: Lorraine Mackstaller, M.D. moved to refer the case to Formal Hearing.
SECONDED: Ram R. Krishna, M.D.
VOTE: 9-yay, 0-nay, 0-abstain/ 2-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
21.	MD-05-0341A MD-05-0434A MD-05-0701A MD-05-0702A MD-05-0703A MD-05-0704A MD-05-0705A MD-05-1062A MD-06-0238A	S.O. J.S. L.K. B.L. B.G. V.R. J.K. M.K. S.B.	CYNTHIA MODNY, M.D.	22577	Issue an Interim Order for a Board approved Psychiatric Evaluation within 60 days.

Victoria Kamm, Senior Medical Investigator summarized the case. She said the complainants described Cynthia Modny, M.D.'s examinations as "brief", yet all were billed as comprehensive examinations. The patients also complained of odd behavior by Dr. Modny in that they could not present for an office visit if they were wearing any type of solvent – perfume, deodorant, dry cleaned clothing, hairspray. It was found that Dr. Modny leaves the doors and windows open when performing an examination, compromising a patient's privacy. Ms. Kamm said Dr. Modny was interviewed by Staff, at which time Dr. Modny explained she had a multiple chemical sensitivity that caused migraines and required the room be well ventilated when examining patients. At the conclusion of that interview Staff made some suggestions to Dr. Modny to alleviate patient's concerns. However, following the interview with Staff, two additional complaints came forward with the same allegations. Kelly Sems, M.D., Medical Consultant said she had concerns about Dr. Modny's behavior and found her medical records were inadequate.

MOTION: Tim B. Hunter, M.D. moved to issue an Interim Order for a Board approved Psychiatric evaluation within 60 days.
SECONDED: Patrick N. Connell, M.D.

Patrick N. Connell, M.D. requested Staff advise the approved Psychiatrist of the Board's concerns so that a pertinent report would be obtained. Staff noted the psychiatrist would be provided with all the relevant material.
VOTE: 10-yay, 0-nay, 0-abstain/recuse, 2-absent
MOTION PASSED.

WEDNESDAY, April 5, 2006

CALL TO ORDER
Robert P. Goldfarb, M.D. called the meeting to order at 9:00 a.m.

ROLL CALL
The following Board Members were present: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., Paul M. Petelin, Sr., M.D.

CALL TO THE PUBLIC
Statements issued during the Call to the Public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0126A	AMB	ABDOL R. ARJMANDFARD, M.D.	33227	Vacate current Interim Consent Agreement and Summarily Suspend the physician's license due to the imminent threat to public health and safety. If the physician waives his right to an expedited hearing the Board requires the hearing to be completed within six months.

Dr. Heidar Arjomand, Dr. Arjmandfard's brother, was present and spoke during the call to the public. Dr. Arjomand said he was a cardiologist and can attest to his brother's caring nature. He said his brother is empathetic, caring, and has a respect for his profession. He said many others have commented that Dr. Arjmandfard is dedicated to his patients.

Barbara Barker, M.D., an Internal Medicine physician, spoke during the call to the public on Dr. Arjmandfard's behalf. She said she has had much experience in peer review, has read the allegations against Dr. Arjmandfard and found them to be unsubstantiated. She said she found the patient to be unstable. She said she and five other physicians observed Dr. Arjmandfard's behavior while on Staff with them and found no inappropriate conduct. Dr. Baker said she found Dr. Arjmandfard to be candid, honest and interviewed patients he saw and found all patient encounters were positive. Dr. Baker said she feels Dr. Arjmandfard should not be limited to seeing female patients only.

Abdol R. Arjmandfard, M.D. was present with counsel, Mr. Steven Myers.

Megan Hinckley Senior Medical Investigator summarized the case for the Board. She said patient K.R. alleges Dr. Arjmandfard would raise her exam gown further than what was necessary for her exam and although she was in a private room, he would pull the drapes closed when examining her. She also alleged Dr. Arjmandfard made inappropriate sexual comments to her repeatedly and inappropriate touched her on several visits. The patient said she expressed to the hospital that she was uncomfortable and wanted a chaperone present during the exams, however this was not provided to her. Dr. Arjmandfard denies all the allegations in this case. Arizona Medical Board Staff found Dr. Arjmandfard denied any previous complaints in his employment history, although Staff found he had a significant prior employment complaint history. The hospital requested a psychological evaluation as a result of this complaint and found he was not honest and recommended he be

evaluated with a professional who specialized in sexual offenders. Dr. Arjmandfard claims the allegations cannot be substantiated because the patient was psychiatrically unstable, however, Staff found that neither hospital staff nor Dr. Arjmandfard ever recorded any odd psychiatric behavior by the patient while in the hospital. Ms. Hinkley and Kelly Sems, M.D., Medical Consultant both informed the Board that during the interview with K.R., she presented as very credible. Mr. Hinckley said K.R. filed a police report with the Mesa Police Department and the investigation is currently ongoing. Ms. Hinckley said Dr. Arjmandfard entered an Interim Consent Agreement with the Arizona Medical Board for an evaluation on February 17, 2006, but violated the agreement by failing to take the polygraph test – a required component of the evaluation. He was evaluated by the Sexual Recovery Institute (SRI) who found he had narcissitic and anti-social personality traits, externalized blame on others, had anger, aggression, poor judgment and poor impulse control.

Dr. Arjmandfard presented his case to the Board. He elaborated on his training and education. He said that after he failed to transfer a patient to a hospital for an insurance reason, he was threatened over the phone by that hospital and immediately following that incident, the allegation of sexual misconduct was brought against him. He said patient K.R. was admitted to the hospital four times, each time under his care and was not in a private room on the second or third admission. He denied performing a pelvic or breast exam on this patient and said he always refers those types of exams to a gynecologist. Dr. Arjmandfard denied any sexual misconduct at any time during his medical career. Although he did admit that he entered into inappropriate personal conversations with female co-workers in his past employment.

Robert P. Goldfarb, M.D. led the questioning and said the Board has reviewed the psychological evaluations of the three psychologists and has also reviewed all documents available in this case. Dr. Goldfarb asked why he saw the patient repeatedly each time she was admitted to the hospital. Dr. Arjmandfard said that on repeat admissions, patients are assigned to the physician who saw them initially. Dr. Arjmandfard said the medical record shows K.R. did not ask to see another physician until the fourth admission. He said she asked the nurse to be present at the time of the third discharge and this was done. Dr. Arjmandfard commented on his employment history. He said he received a letter of "termination for cause" from a previous employer, Apogee Medical Group, but never inquired what the "cause" was, although he was sure it was not for any sexual misconduct. Dr. Arjmandfard said he was placed on suspension at Banner Baywood Hospital for alleged sexual harassment of coworkers and of patient K.R. He said was currently not practicing due to the Consent Agreement. He said he did not realize he was in violation of his Interim Consent Agreement by refusing the polygraph test. He declined to take the polygraph test based on his emotional status at the time because he felt the result would be a false positive. Tim B. Hunter, M.D. asked Dr. Arjmandfard if he would even decline the polygraph test at this time, regardless of whatever consequences the Board may impose as a result of his refusal. Dr. Arjmandfard said he would continue to decline a polygraph test regardless of the consequences.

Tim B. Hunter, M.D. asked Dr. Arjmandfard about the incidents of prior misconduct. Dr. Arjmandfard said he was put on probation for a couple of months during his residency for missing ENT clinic, and also for not accepting feedback when supervising staff spoke to him. He said he worked with Apogee Medical Group until receiving a termination letter and then worked at Banner Baywood until he lost his privileges for several sexual harassment complaints and the complaint from K.R. He said he is currently an employee of a cardiology group, but is not practicing due to the Consent Agreement.

Paul M. Petelin, Sr., M.D. noted that although Dr. Arjmandfard alleges the patient may have made her allegations because she was on psychiatric medications that could cause hallucinations, the medical records show no documentation that any psychiatric behavior was of concern for any of the four admissions. Dr. Arjmandfard said he did not have enough time to evaluate the patient's psychiatric status, and did not see her as delusional because he had limited time with the patient. He said she was non-compliant with her discharge instructions and that proved she did not display behavior of a rational person. William R. Martin, III, M.D. noted that if the physician wanted to use the patient's status as a mitigation factor in this case, there was a quality of care issue because, by his own admission, the patient's condition would have been significant enough to be treated or looked at by Dr. Arjmandfard.

Sharon B. Megdal, Ph.D. commented that the SRI report found Dr. Arjmandfard had an inability to accept responsibility. She said that based on Dr. Arjmandfard's testimony before the Board that K.R.'s allegation was a result of his failure to transfer a patient to a hospital, his reasoning concurred with the SRI report findings.

Mr. Meyers made closing comments stating there was no credible evidence that the physician engaged in unprofessional conduct. The patient's story is not believable because she alleged outrageous sexual abuse, but reported it to no one. He said the patient was on a cocktail of narcotics, five of which have hallucinogenic side effects. Dr. Meyers said Dr. Arjmandfard should have never been sent to SRI because there have been no other reports of sexual misconduct with any other patient.

Kelly Sems, M.D., Medical Consultant said Staff has performed a thorough review of this case and did a research of the patient's medications and side effects. She said the hospital records show that at no time during any hospital stay did the patient show any hallucinations or uncooperative behavior.

The Board went into Executive Session at 10:14 a.m.
The Board returned to Open Session at 10:30 a.m.

Dr. Goldfarb said the allegation of inappropriate conduct with the same patient occurred on more than one occasion and that Dr. Arjmandfard was suspended from the hospital for those issues. He said Dr. Arjmandfard signed an Interim Consent Agreement for a psychosexual evaluation that he refused to fully complete by refusing to complete the polygraph test. Dr. Goldfarb also noted that Dr. Arjmandfard felt certain employees at SRI were hostile toward him. Dr. Goldfarb said the Board would be severely handicapped in assessing the physician's mental and physical status of its licensees if physicians choose what examinations they were and were not willing to take. Dr. Goldfarb said Dr. Arjmandfard has had three psychological evaluations and all three evaluations have had compelling recommendations for treatment of the physician. Dr. Goldfarb said that considering the preponderance of evidence both in the file and by the physician's testimony, he believed the Board should take a summary action.

MOTION: Robert P. Goldfarb, M.D. moved to vacate current Interim Consent Agreement and Summarily Suspend the physician's license due to the imminent threat to public health and safety. If the physician waives his right to an expedited hearing the Board requires the hearing to be completed within six months.
SECONDED: Douglas D. Lee, M.D.

Dr. Mackstaller said this was a serious allegation and she hopes the patient is being forthright because it gives serious consequences to the physician. Dr. Hunter said he was not convinced this was an eminent danger to the public.

Dr. Connell said there were various issues during the residency and that Dr. Arjmandfard was not forthright about in his testimony in front of the Board. There are repetitive allegations and SRI made significant findings concerning this physician.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., and Paul M. Petelin, Sr., M.D. The following Board Members voted against the motion: Patricia R.J. Griffen, Tim B. Hunter, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, R.N., Ph.D.
VOTE: 8-yay, 4-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-05-0884A	MCSO	HARSHAD PATEL, M.D.	22757	Draft Findings of Fact, Conclusions of Law and Order for Decree of Censure for unprofessional conduct and five (5) year Probation with Practice Restriction to follow the treatment recommendations from PCS and Pinegrove, practice 30 hours a week, with male patients only, with a licensed healthcare professional present. The physician may not request early termination from Probation. The physician may petition the Board a modification of the Probation.

Harshad Patel, M.D. was present with counsel Mr. Paul Giancola.

Vicki Johansen, Senior Medical Investigator summarized the case for the Board. The Board received an allegation of sexual misconduct against Dr. Patel. The patient's testimony was consistent both to Board Staff and to the Maricopa County Sheriff's Office (MCSO). Dr. Patel's statements of the case were not consistent to Board Staff and MCSO. On October 21, 2005 Dr. Patel entered into a practice restriction and agreed he would not treat female patients. In November 2005 he submitted to the Sexual Recovery Institute (SRI) where he admitted to the patient's allegations in this case. On November 22, 2005 he, on the recommendation of SRI, entered treatment at Pinegrove. On December 9, 2005 Dr. Patel entered into a Consent Agreement for Practice Restriction that remains in effect and prohibits him from performing clinical medicine or any patient care. On March 1, 2006 the Executive Director reported the evidence of criminal conduct to the Maricopa County Sherriff's Office (MCSO). The criminal investigation is still ongoing.

Mr. Giancola, asked the Board not discuss the patient's visit with Dr. Patel on August 15, 2005 as it is still is the subject of an ongoing investigation by MCSO.

Dr. Patel said he regrets his actions and has tried to understand his behavior. He said he was willing to continue his rehabilitation with the Board's monitoring program.

Sharon B. Megdal, Ph.D. led the questioning. She said the case has been thoroughly reviewed and discussed by the Board previously and the details of the case did not need to be reiterated. Dr. Megdal noted Dr. Patel was not forthright in failing to admit to the allegations of this case when initially questioned by the Board.

Dr. Megdal had Dr. Patel describe the appropriate treatment for vaginitis and appropriate follow up. Dr. Patel described the treatment and follow up of vaginitis and said there are a mixed number of patients who see him for pelvic exams and who go to gynecologists for their pelvic exams. He said he was not currently practicing due to his Consent Agreement with the Board.

Dr. Megdal said there was admitted evidence that Dr. Patel did not follow the standard of care in the treatment of vaginitis and, by his own testimony, the patient's allegations were supported.

MOTION: Sharon B. Megdal, Ph.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27) (q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public and A.R.S. §32-1401 (27) (z) - Engaging in sexual conduct with a current patient or with a former patient within six months after the last medical consultation unless the patient was the licensee's spouse at the time of the contact or, immediately preceding the physician-patient relationship, was in a dating or engagement relationship with the licensee, for purposes of this subdivision, "Sexual Conduct" includes:
(i) Engaging in or soliciting sexual relationships, whether consensual or nonconsensual.
(ii) Making sexual advances, requesting sexual favors or engaging in other verbal conduct or physical contact of a sexual nature.
(iii) Intentionally viewing a completely or partially disrobed patient in the course of treatment if the viewing is not related to patient diagnosis or treatment under current practice standards.

SECONDED: William R. Martin, III, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

Dr. Megdal noted there was a professional recommendation that Dr. Patel could return to practice.

MOTION: Draft Findings of Fact, Conclusions of Law and Order for Decree of Censure for unprofessional conduct and five (5) year Probation with Practice Restriction to follow the treatment recommendations from PCS and Pinegrove, practice 30 hours a week, with male patients only, with a licensed healthcare professional present. The physician may not request early termination from Probation. The physician may petition the Board a modification of the Probation.

SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., and Paul M. Petelin, Sr., M.D.
The following Board Member Abstained: Lorraine Mackstaller, M.D.
VOTE: 11-yay, 0-nay, 1-abstain 0-recuse, 0-absent
MOTION PASSED.

Christine Cassetta, Board Legal Counsel suggested the Board vacate the Interim Practice Restriction and offer a new Interim Consent Agreement for Practice Restriction, limiting his practice to 30 hours per week; restricted to male patient's only in the presence of a chaperone; shall undergo therapy; shall undergo follow-up evaluation, and complete sex offense study treatment. The Board agreed with Ms. Cassetta's suggestion and Dr. Megdal said she had meant to bring that up as a recommendation and thanked Ms. Cassetta for mentioning it.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-05-0013A MD-05-0681A MD-05-0605A MD-05-1018A	AMB	SUDHIR GOEL, M.D.	27103	Vacate the current Interim Consent Agreement and Summarily Suspend the physician's license due to the imminent threat to the public. The matter will be referred to formal hearing for revocation or stayed revocation.

Sudhir Goel, M.D. was present with counsel Mr. Paul Giancola.

Mr. Giancola said this case was subject to investigation by the Maricopa County Sheriff's Office and requested the details of the patients and care provided to them not be discussed at this time. Mr. Giancola said Dr. Goel requesting the Board allow him to continue his rehabilitation at this time and was not requesting re-issuance of license presently.

Dr. Goel said he was truly sorry for his mistakes and said he can assure the Board he will not repeat this behavior. He said he has suffered great personal losses because of his behavior. He said he has gained insight through his completion of intensive treatment, but has much work left to do. He said he will be reentering Pinegrove's treatment in June 2006.

Patricia Reynolds, Assistant Manager of Investigations summarized the case for the Board. The Board previously heard the four cases for sexual misconduct and restricted Dr. Goel's practice to male patient's only. On August 8, 2005 Dr. Goel entered into a Consent Agreement for psychosexual evaluation. The results recommended he not treat female patients until he completes a course of treatment related to sexual boundaries. Dr. Goel voluntarily submitted to the Sexual Recovery Institute (SRI). SRI diagnosed him with AXIS I: Sexual Abuse of Adult (multiple reports). On December 8, 2005 Dr. Goel entered into an Interim Consent Agreement for Practice Restriction to not practice clinical medicine or any medicine until successful discharge from Pinegrove Treatment Center. The evidence of the criminal conduct was reported to the Phoenix Police Department by the Arizona Medical Board.

William R. Martin, III, M.D. led the questioning. He asked Dr. Goel if he agreed with the diagnosis of SRI. Dr. Goel said he did. Dr. Goel admitted he did not believe there was any corroboration between the four separate patients who made similar sexual misconduct complaints. Dr. Goel said he agreed he had a problem with female patients, has submitted to four months of intensive treatment and has gained insight into his behavior, and admits he has much work left to do.

Patrick N. Connell, M.D. said he felt the Board was handcuffed by the physician's counsel by not being able to discuss details of the patient's allegations and therefore there was not enough information or which to base a decision.

Dr. Martin referred to the October 7, 2005 interview transcript page 16, line 14 through 16 where Dr. Goel had testified that the patient's allegation was "an absolute lie". Dr. Martin said that in order to be rehabilitated Dr. Goel must first admit his behavior, which he is not convinced he has done.

Mr. Giancola said the treatment providers Dr. Goel is under will not recommend he can return to practice without the clear acknowledgement of his behavior.

MOTION: Patrick N. Connell, M.D. moved to vacate the current Interim Consent Agreement and Summarily Suspend the physician's license due to the imminent threat to the public. The matter will be referred to formal hearing for revocation or stayed revocation.
SECONDED: Sharon B. Megdal, Ph.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., and Paul M. Petelin, Sr., M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-02-0828A	AMB	JAMES F. BLUTE, M.D.	6998	Issue an advisory letter for a delay in diagnosis of and treatment of a complication and for inadequate medical records. This does not rise to the level of discipline.

James Blute, M.D. was present without counsel.

Robert P. Goldfarb, M.D. said he knows Dr. Blute professionally but it will not affect his ability to adjudicate the case.

Ingrid Haas, M.D., Medical Consultant summarized the case for the Board. The case came to the Board via a malpractice case. Dr. Blute performed a total abdominal hysterectomy and a post operative visit showed no abnormalities. It was eventually discovered that there was a suture in the bladder that required the patient have a laparotomy for removal and repair. The allegations were that he negligently performed the procedure by placing a suture in the bladder, failed to evaluate and treat the patient's postoperative complaints, had poor medical record keeping and provided false or misleading information to the Board based in the investigative interview with Staff in November 2003.

Pearl Reed, Senior Medical Investigator elaborated on the false information Dr. Blute presented to the Board at the November 2003 interview. Dr. Blute told Staff the medical records for this case were purged; however, Staff subpoenaed the records and obtained them. Ms. Reed said it was unclear if Dr. Blute was confused with the interview questions as there was no evidence that he knowingly lied to Board Staff.

Paul M. Petelin, Sr., M.D. led the questioning. Dr. Blute said he no longer practices patient care, but does some administrative and teaching duties. Dr. Blute said he realizes the Board is correct in its findings of more medical records and that it was not intent his to deceive Staff, but that he had different records than the Board had. He said Board Staff was able to obtain one additional record than what he had in his possession but that record did not change the findings in this case. Dr. Petelin noted in Dr. Blute's licensee response he said the plaintiffs' were unable to find an expert witness, yet a plaintiff expert witness had made statements a significant amount of time before his licensee response was written. Dr. Blute said he was not aware that there was an expert witness in the case until the Arizona Medical Board notified him.

Tim B. Hunter, M.D. asked why he did not respond in a timely manner to the malpractice case and Dr. Blute responded that was because he was not informed in a timely manner of the case.

MOTION: Paul M. Petelin, Sr., M.D. moved to find unprofessional conduct in violations of A.R.S. §32-1401 (27) (e)- Failing or refusing to maintain adequate records on a patient, A.R.S. §32-1401 (27) (q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Tim B. Hunter, M.D.
VOTE: 11-yay, 1-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

Dr. Petelin said he found the follow up of this patient delayed the diagnosis and the treatment that could have otherwise been fixed easily if it had been recognized or treated earlier. He said, however, he did not believe this case rose to a level of discipline.

MOTION: Paul M. Petelin, Sr., M.D. moved to Issue an advisory letter for a delay in diagnosis of and treatment of a complication and for inadequate medical records. This does not rise to the level of discipline.
SECONDED: Tim B. Hunter, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., and Paul M. Petelin, Sr., M.D.
The following Board Members voted against the motion: Ram R. Krishna, M.D.
VOTE: 11-yay, 1-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-05-1033A	AMB	MICHAEL HERION, M.D.	30486	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for Internet prescribing and a $1,000 civil penalty.

Michael Herion, M.D. was present with counsel Mr. Gordon Bueler.

Kelly Sems, M.D., Medical Consultant summarized the case by saying the Board received an allegation that Dr. Herion deviated from the standard of care by prescribing over the internet without performing history and physicals. Staff found he earned over $85,000.00 during the time he prescribed over the internet.

Mr. Beuler said Dr. Herion was not aware he was in error and he contacted the Board to ask of his conduct prior to the Board opening an investigation. He said he immediately ceased internet prescribing when the Staff referred him to the statute that said it was a violation of the Medical Practice Act. Dr. Herion had been told by the internet company he worked for that internet prescribing was lawful and appropriate. He said that at the time this occurred Dr. Herion had relative inexperience in the practice of medicine at the time as he was a resident. He said Dr. Herion has been cooperative with the Board throughout the investigation.

Robert P. Goldfarb, M.D. led the questioning. Dr. Goldfarb noted the Board received an anonymous complaint prior to the physician contacting the Board to ask about his prescribing. Dr. Goldfarb noted that although the internet company Dr. Herion worked for required patients to fill out a questionnaire on-line, there was no way to authenticate the information on the questionnaire. Dr. Herion admitted he did not obtain patient records from treating physicians, but that he would not supply antidepressant medications without the treating physician knowing.

Lorraine Mackstaller, M.D. asked Dr. Herion how he was reimbursed. He said he would receive anywhere from $2 to $6 per consult. He said he did consider the risk of abuse and was assured by a pharmacist that there were shields in place to prevent patients from fraudulently obtaining prescriptions. Dr. Herion admitted he was not qualified to treat primary pain or depression, but rather would fill medications they were prescribed by a treating physician. He said he believed the company provided low cost medications to patients who did not have insurance. Dr. Herion said the company he worked for gave him some records and reassurance that the patients had primary care physicians. Dr. Herion said that although he was only paid if he approved the prescription, he did not feel he allowed this to cloud his judgment. He said he was very convinced by the company that they had all the correct procedures in place. He said he does recognize a history and physical must be done for each patient and that he was not performing a history and physical when prescribing on-line.

William R. Martin, III, M.D. verified that it was not until he received a call from a government official stating he was in trouble for his prescribing that he contacted the Board and ceased his practice. Dr. Herion admitted this and said the government official was the first person who alerted him that he was engaged in inappropriate conduct.

Dr. Goldfarb said he believes the physician used bad judgment before becoming involved in internet prescribing. Dr. Goldfarb also noted it appeared Dr. Herion was not familiar with the Medical Practice Act in Arizona.

MOTION: Robert P. Goldfarb, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27) (e)- Failing or refusing to maintain adequate records on a patient, A.R.S. §32-1401 (27) (q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public, A.R.S. §32-1401 (27) (ss) - Prescribing, dispensing or furnishing a prescription medication or a prescription-only device as defined in section 32-1901 to a person unless the licensee first conducts a physical examination of that person or has previously established a doctor-patient relationship. This subdivision does not apply to:
(i) A physician who provides temporary patient supervision on behalf of the patient's regular treating licensed healthcare professional.
(ii) Emergency medical situations as defined in section 41-1831.
(iii) Prescriptions written to prepare a patient for a medical examination.
(iv) Prescriptions written or prescription medications issued for use by a county or tribal public health department for immunization programs, emergency treatment, in response to an infectious disease investigation, public health emergency, infectious disease outbreak or act of bioterrorism. For the purposes of this item, "bioterrorism" has the same meaning as prescribed in section 36-781.
SECONDED: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

Dr. Goldfarb noted it was mitigating in that the physician realized his error, is repentive and no longer continues to prescribe over the internet. Due to the mitigating factors, Dr. Goldfarb said he felt that because of that the civil penalty should be reduced from what the Staff Investigational Review Committee (SIRC) recommended.

MOTION: Robert P. Goldfarb, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for Internet prescribing and a $1,000 civil penalty.
SECONDED: Ram R. Krishna, M.D.

Douglas D. Lee, M.D. spoke against the motion because he said the physician's testimony was convincing in that although he should have known the laws, he did not have any intention for disobeying the laws. Dr. Hunter said he believes the Board should be consistent as in other cases where internet prescribing was present and that consistency was important to help get the message to other physicians that internet prescribing is not tolerated in Arizona. Dona Pardo, R.N., Ph.D. said physicians should know the statutes under which they are working. Lorraine Mackstaller, M.D. said that Dr. Herion prescribed Tramadol repetitively to a variety of patients, which was below the standard of care.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., and Paul M. Petelin, Sr., M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-03-0174A	H.W.	JOHN HENSLER, M.D.	5346	Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for inappropriate billing, inadequate medical records, mismanagement of an addicted patient, and failure to diagnose pneumonia in a timely manner resulting in the death of the patient. Two year Probation with a chart review at the end of the year and 20 hours Board approved CME in recordkeeping and in billing and coding. Within 180 days, obtain a practice evaluation at PACE and submit the results to the Board for further action if needed. In addition, Dr. Hensler shall pay a $5,000 civil penalty. The physician may request termination of the Probation after one year.

John Hensler, M.D. was present with counsel Mr. Charles Buri.

Paul M. Petelin, Sr., M.D. said he knows Dr. Hensler but it will not affect his ability to adjudicate the case.

Kelly Sems, Medical Consultant summarized the case to the Board: The allegation against Dr. Hensler is failure to diagnose and treat R.W.'s pneumonia ultimately resulting in the patient's death and failing to intervene in the patient's long history of substance abuse.

Dr. Hensler said the patient was unique and complex in that he had a unique psychological background that Dr. Hensler was not aware of at first. Dr. Hensler said he tried to have the patient come in a couple days before the patient's death, but the patient did not present at that time. Dr. Hensler said that regarding the allegation of failure to treat substance abuse, he said he was asked to treat the patient's medical problems not his substance abuse.

Patrick N. Connell, M.D. led the questioning. Dr. Connell noted it was below the standard of care to treat a substance abuse patient with opiates and fail to refer the patient to a pain management specialist. Dr. Connell noted Dr. Hensler prescribed Ultram and Paxil to R.W. although those medications were contraindicated in a patient with a history of seizures. Dr. Hensler said he was not certain the patient had seizures and that although he treated R.W. for seizures, he did not find evidence of either prior or present seizure disorder in the patient.

Dr. Connell noted Dr. Hensler ordered an excess of lab work for R.W. Dr. Hensler claims he was monitoring bronchitis and anemia by ordering repeat complete blood counts (CBCs). Dr. Connell stated that Dr. Hensler ordered a thyroid panel on R.W. four times during one month and 15 cholesterol determinations within three months, which was excessive. Dr. Hensler said the patient had a difficult personality and would demand Dr. Hensler to order tests for him and persistently call the office until he got what he wanted. However, Dr. Hensler said he did not think R.W. had psychiatric problems while under his care and noted he was only trying to treat his acute illness and not provide psychiatric treatment.

Dr. Connell noted the medical record showed the patient complained of shortness of breath, but Dr. Hensler did not document any specifics regarding the duration of the shortness of breath or chest pain.

Dr. Connell noted the patient was a morbidly obese 46-year-old male with tachycardia and complaints of shortness of breath, yet Dr. Hensler did nothing to rule out pulmonary embolism, cardiac disease or pneumonia. Dr. Hensler said he gave the patient Kenalog and Benadryl because the patient alleged he had an allergy to MSG in the food he ate. Dr. Connell noted the medical record showed Dr. Hensler was prescribing multiple medications without substantiating the reason. Dr. Hensler said he thought R.W. had bronchitis and gave two antibiotics at the same time to treat the patient. Dr. Connell said while under Dr. Hensler's care the patient continued to gain weight, his heart rates continued to escalate, and he died from a continually worsening case of pneumonia. He said Dr. Hensler charged R.W.'s trust fund for comprehensive visits three to four times a week, but he did noting to address the patient's issues.

Lorraine Mackstaller, M.D. noted it was Dr. Hensler's testimony that he tried to see the patient 2-3 days before he died, but the patient did not present to the office. However, Dr. Mackstaller noted Dr. Hensler billed for a patient appointment on the two days he said the patient did not present. Dr. Mackstaller noted Dr. Hensler billed almost every day of the month on month for a total of about $4,200.00 and many times did not have progress notes to match the billing.

Douglas D. Lee, M.D. noted Dr. Hensler repeatedly ordered more tests and gave more medications, but there was nothing in the records that showed that he had a treatment plan for a patient.

Paul M. Petelin, Sr., M.D. said he found Dr. Hensler ordered tests excessively, but made no medical decisions based on the test results. Dr. Hensler said that many times the patient would have an appointment that lasted two hours because he would rant and rave over various frustrations. Dr. Hensler said he would charge for a comprehensive exam for these visits because he felt that was a sufficient way to be reimbursed with the amount of time he spent with the patient. Dr. Petelin said the billing code for a comprehensive exam is determined by the amount of time spent with a patient, but found that Dr. Hensler inappropriately billed because there was no evidence in the medical record of comprehensive exams.

Tim B. Hunter, M.D. noted it was Dr. Hensler's testimony that he felt he had to care for the patient because he agreed to during a deposition. Dr. Hunter said he could have petitioned the judge or have given the patient 30 days to find another physician and that would not have been patient abandonment.

Mr. Buri made closing statements. He said this is one patient and this is not reflective of Dr. Hensler's general care. He said The Maricopa Superior Court ordered the patient was to see Dr. Hensler every week and even if he would have discharged the patient, the patient would have continued coming back because he was very controlling. Mr. Buri said Dr. Hensler has acknowledged his records are inadequate, but has since changed his practice and keeps better records.

Patrick N. Connell, M.D. said Dr. Hensler charged for 89 comprehensive exams that did not meet the standards for comprehensive exams. Dr. Connell said two-hour patient visits were not the standard of care, and that Dr. Hensler inappropriately prescribed with no rationale or documentation to justify the prescription. Dr. Connell noted there was bizarre lab work that was never addressed and 10 office visits of progressive dyspnea that was never addressed by Dr. Hensler. Dr. Connell said he found this to be repeated negligence because Dr. Hensler had many opportunities to appropriately diagnose the patient.

MOTION: Patrick N. Connell, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27) (e)- Failing or refusing to maintain adequate records on a patient, A.R.S. §32-1401 (27) (q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public., A.R.S. §32-1401 (27) (w) - Charging or collecting a clearly excessive fee. In determining if a fee is clearly excessive, the Board shall consider the fee or range of fees customarily charged in the state for similar services, in light of modifying factors - such as the time required, the complexity of the service and the skill requisite to perform the service properly. This subdivision does not apply if there is a clear written contract for a fixed fee between the physician and the

patient that has been entered into before the provision of service and A.R.S. §32-1401 (27) (ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

Dr. Lee said he questions the physician's competency and Robert P. Goldfarb, M.D. said he was concerned about Dr. Hensler's use of antibiotics.

MOTION: Patrick N. Connell, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for inappropriate billing, inadequate medical records, mismanagement of an addicted patient, and failure to diagnose pneumonia in a timely manner resulting in the death of the patient. Two year Probation with a chart review at the end of the year and 20 hours Board approved CME in recordkeeping and in billing and coding. Within 180 days, obtain a practice evaluation at PACE and submit the results to the Board for further action if needed. In addition, Dr. Hensler shall pay a $5,000 civil penalty. The physician may request termination of the Probation after one year.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D.,and Paul M. Petelin, Sr., M.D.
The following Board Member abstained: Patricia R.J. Griffen
VOTE: 11-yay, 0-nay, 1-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-04-1543B	C.C.	MICHAEL CAMPION, M.D.	16283	Issue an Advisory Letter for inserting the wrong intraocular lens into the patient's eye. The conduct has been remediated.

Michael Campion, M.D. was present with Mr. Michael Ryan.

Mark Nanney, M.D., Chief Medical Consultant summarized the case. Patient C.C. underwent cataract surgery and the wrong intraocular lens was placed. Dr. Campion said the mistake was due to a technical error. Dr. Nanney told the Board he had several cases similar to this case pending and that he needed the Board's direction how these types of cases should be handled. Specifically Dr. Nanney asked for direction for if the physician or the attending staff should be held accountable in technical errors such as in this case. The Board answered that such cases should be evaluated independently for determination of the burden of responsibility for the error.

Dr. Campion said he was very regretful this incident occurred. Dr. Campion said a different lens calculation was placed in the patient's chart by mistake and he chose the inappropriate lens based on those calculations. He said two nurses missed the error also before giving him the chart. Dr. Campion said the error was discovered the day following surgery and was corrected within twenty-four hours. Dr. Campion said this was the first time this type of error had occurred in his practice and he has made changes in the procedures since to prevent this from reoccurring. Dr. Campion said that now, three separate people verify the patient's information is correct prior to surgery and the information is bound in the file as opposed to loosely placed in the chart. Dr. Campion said no incidents have occurred since this time.

Robert P. Goldfarb, M.D. led the questioning. Dr. Campion admitted the patient's name was printed on the top of the A-scan and that he failed to observe the incorrect patient's A-scan was in the chart. Paul M. Petelin, Sr., M.D. had Dr. Campion describe in detail the checks and balances now in place in his practice in order for him to avoid this mistake in the future. Dr. Pardo noted there were also two nurses who missed the error of the incorrect A-scan in the patient's medical record. William R. Martin, III, M.D. noted it was Dr. Campion's testimony that although he missed the patient's name on the top of the A-scan, he met the standard of care for this patient and should not be faulted for a clerical error by staff.

Mr. Ryan said Dr. Campion is an employee physician is not responsible for supervision of staff members at his place of employment. Mr. Ryan said Dr. Campion does admit he missed the patient's name and has taken affirmative steps to assure this does not occur again.

Dr. Goldfarb said it was substantiated that Dr. Campion implanted the wrong lens during cataract surgery resulting in subsequent surgery for the patient.

MOTION: Robert P. Goldfarb, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401(27) (q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Tim B. Hunter, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

Becky Jordan said she felt this was a one time technical error and Dr. Campion has done everything he can to prevent it in the future. Lorraine Mackstaller, M.D. said she can see how this error could easily occur in a practice. Robert P. Goldfarb, M.D. said he did not believe this was an intentional act on the part of the physician, but the patient did suffer harm and did require a second operative procedure.

MOTION: Robert P. Goldfarb, M.D. moved to Draft Findings of Fact Conclusions of Law for a Letter of Reprimand for inserting the wrong intraocular lens into the patient's eye. The conduct has been remediated.
SECONDED: Tim B. Hunter, M.D.

Ram R. Krishna, M.D. said he believed there were mitigating factors in this case because two other professionals missed the error before giving the chart to the physician. Dr. Lee said he agreed with Dr. Krishna because if he would have followed the nurses' advice, which is allowable by the standard of care, and not have looked at the file himself, he would have not been brought to the Board. Dona Pardo, R.N., Ph.D. said it is nursing responsibility to ensure the correct patient's name is in the correct chart. Dr. Hunter said it was aggravating that it was the correct patient's name on the A-scan and that this case would have been more easily excused if the A-scan had been inappropriately labeled.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Tim B. Hunter, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, R.N., Ph.D. The following Board Members voted against the Motion: Patrick N. Connell, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., and Paul M. Petelin, Sr., M.D.
VOTE: 5-yay, 7-nay, 0-abstain/recuse, 0-absent
MOTION FAILED.

MOTION: Patrick N. Connell, M.D. moved to issue an Advisory Letter for inserting the wrong intraocular lens into the patient's eye. The conduct has been remediated.
SECONDED: Lorraine Mackstaller, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., and Paul M. Petelin, Sr., M.D. The following Board Member voted against the motion: Robert P. Goldfarb, M.D.
VOTE: 11-yay, 1-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

MOTION: Dona Pardo, R.N., Ph.D. moved to refer the nurses in the case to The Arizona State Board of Nursing.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-05-0243A	AMB	JAY S. NEMIRO, M.D.	12781	Issue an Advisory Letter for the transfer of five embryos in the index patient in this case resulting in a quintuplet pregnancy. The physician has changed his practice and it is unlikely to happen again.

Charles Hawk a patient of Dr. Nemiro was present and spoke during the call to the public. He said he felt Dr. Nemiro's specialty of infertility is highly competitive monetarily and that the anonymous complaint in this case may have been filed by a professional rather than a patient. Mr. Hawk said he feels Dr. Nemiro has perfected his procedure of zygote intrafallopian transfer (ZIFT) and gamete intrafallopian transfer (GIFT) to assist in infertility and that sanctioning him would take away a great service from other patients who can benefit from his care.

Jennifer Hunter, patient of Dr. Nemiro, spoke during the call to the public. She said she consulted two other fertility physicians who told her they were out of ideas to help her and that she should wait 2-3 years to see if technology improved as her last option. She said, however, Dr. Nemiro was able to give her a child and she would eventually like to have another child and feels that if Dr. Nemiro is put out of practice, her opportunity will be lost. Ms. Hunter said Dr. Nemiro is the only physician in the Valley who does the GIFT and ZIFT procedures.

M.G. spoke on behalf of Dr. Nemiro during the call to the public. He said his wife had six In-vitro fertilizations (IVF). He said the first four were uneventful, the fourth resulted in a major complication and the sixth IVF proceeded without complications but also failed. He said their physician suggested they undergo no additional IVF procedures, but recommended Dr. Nemiro to them. M.G. said that from their first GIFT procedure from Dr. Nemiro, they were able to have their first child. He said they were able to have three additional children with Dr. Nemiro's help and without Dr. Nemiro he and his wife would be childless.

Jay Nemiro, M.D. was present with legal counsel Ms. Isabel Humprey.

Mark Nanney, M.D., Chief Medical Consultant summarized the case for the Board. The case was brought to the Board's attention by an anonymous complaint. The Outside Medical Consultant noted the standard of care required that not more than two embryos should be placed during a procedure and that Dr. Nemiro placed five embryos during the procedure in this case. Dr. Nanney also noted that the GIFT/ZIFT procedures should be rare, but Dr. Nemiro does them at an extremely high rate.

Dr. Nemiro said he performs more ZIFT and GIFT procedures because he has found IVF procedures are largely unsuccessful. Dr. Nemiro said he does not deny he does more of the ZIFT/GIFT procedures than anyone else in the country and said that the American Society of Reproductive Medicine as well as The Society of Assisted Reproductive Technologies has never issued any directives to reduce the number ZIFT/GIFT procedures performed. Dr. Nemiro said the GIFT procedure is the only procedure approved by the American Catholic Church. Dr. Nemiro said he has delivered 6,000 plus pregnancies and most of them were due to ZIFT/GIFT procedures. He said he has spent his entire professional career perfecting these procedures along with using the IVF procedure.

Patrick N. Connell, M.D. led the questioning. Dr. Connell said Dr. Nemiro consulted on a family member of his about 20 years previously, but it will not affect his ability to adjudicate the case.

Dr. Connell referred to a letter written by a physician who was a clinical professor at Harvard that had been submitted to the Board by Dr. Nemiro. The letter said it was atypical to place five eggs in the uterus. Dr. Nemiro said he wished to place less than five embryos in uterus, but succumbed to pressure from the biological parents to put more embryos in and said he will not allow himself to succumb to pressure of this type

again. Dr. Nemiro said that the odds that all five eggs would thrive were low and he was very surprised when this occurred. Dr. Connell noted that in 2001 Dr. Nemiro's triplet rate was higher than the national average in that the national average was 8.1 and Dr. Nemiro's average was at 28.1.

Dr. Nemiro said the 2004 guidelines clarify that prior guidelines were not meant to determine the number of embryos meant to be placed. He said the parents in this case, because of their financial condition, could only have one try at this procedure. Dr. Connell noted patients will ask for things that are not in their best interests and that the guidelines are in place to protect patients and the guidelines do not consider financial strain. Dr. Nemiro said a quintuplet pregnancy as a result of five embryos placed has never before happened in his practice. Dr. Nemiro said he felt more comfortable with his actions at the time because all parties were open to selective reduction. Dr. Connell noted that in an emotional case such as the success of pregnancy, selective reduction would be hard for parents to consider. Dr. Nemiro said he does not rely on selective reduction. Paul M. Petelin, Sr., M.D. said Dr. Nemiro testified that part of his motivation was economic, but as a result, he gave the parents the financial hardships of five children. Dr. Nemiro said that because of this case he has changed his practice pattern and will now never put back more than three embryos.

Dr. Nemiro said he always gives patients the choice between the ZIFT/GIFT and IVF, lets them know he has a higher success rate with the ZIFT, but also notifies them of the risks. Dr. Connell said he wonders how rationally the patient understood that choice because they never had failed at any other procedure as this was their first attempt. Dr. Connell also noted the patients were not fluent in English and used a family member as an interpreter. Dr. Connell said it is not prudent to use a family member to interpret because they are not objective.

Dr. Connell said the statistics of Dr. Nemiro's success rates are no higher than the national figures, yet he does far more ZIFT procedures than anyone else. Dr. Connell said this may stand to reason that the ZIFT procedure is not significantly better than the IVF procedure. Dr. Nemiro said a large amount of his patients have been turned down by other clinics or have had unsuccessful results with other procedures. Dr. Nemiro said he speaks to patients about the risks of multiples based on the number of transfers done.

Ms. Humprey said the ZIFT/GIFT procedures are safe and effective. Dr. Nemiro's percentage of cycles resulting in pregnancies was much higher than the national average. She said the percentage of singleton births was 36.6 percent on national average but that Dr. Nemiro's percentage of singleton births was 126.6 percent. She said the surrogate and biological parent in this case were fully informed of the risk of placing five embryos.

Patrick N. Connell, M.D. said by his own testimony Dr. Nemiro would agree he did not make a good choice in this case and it was not something he would repeat. However, the evidence shows there was a potential for harm in this case. Dr. Connell said that although there are practice guidelines, there are sometimes good reasons to go outside the practice guidelines. He said he would not recommend the Board restrict Dr. Nemiro's choice of procedures in dealing with infertile patients.

MOTION: Patrick N. Connell, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27) (q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: William R. Martin, III, M.D.

Dr. Hunter said he did not want to be in the position to say that a physician can or cannot do a procedure when there is no guideline prohibiting it. Robert P. Goldfarb, M.D. said he agreed with Dr. Connell and Dr. Hunter that the Board should not restrict the options offered by Dr. Nemiro as long as his complication rates are statistically in the normal average range.

VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

Patrick N. Connell, M.D. said Dr. Nemiro understands his error, expressed remorse in his testimony, and believes that he will not allow this to occur again.

Douglas D. Lee, M.D. said he did not believe this was not a question of whether ZIFT or GIFT should be allowed to be done, but whether it was done appropriately in this case.

MOTION: Patrick N. Connell, M.D. moved to issue an Advisory Letter for the transfer of five embryos in the index patient in this case resulting in a quintuplet pregnancy. The physician has changed his practice and it is unlikely to happen again.
SECONDED: Robert P. Goldfarb, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, R.N., Ph.D.
The following Board Members voted against the Motion: Douglas D. Lee, M.D., Paul M. Petelin, Sr., M.D.
VOTE: 10-yay, 2-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

MOTION: Patrick N. Connell, M.D. moved to rescind the Interim Consent Agreement for Practice Restriction.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

THURSDAY, April 6, 2006

CALL TO ORDER
Robert P. Goldfarb, M.D. called the meeting to order at 8:00 a.m.

ROLL CALL
The following Board Members were present: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., Ph.D., and Paul M. Petelin, Sr., M.D. The following Board Members joined the meeting later in the morning: Sharon B. Megdal, Ph.D. and Becky Jordan.

CALL TO THE PUBLIC
Statements issued during the Call to the Public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-05-0656A	AMB	CHARLES MATLIN, M.D.	13975	Issue an advisory letter for failure to fully document the treatment options available.

Charles Matlin, M.D. was present with counsel Ms. Christina Chait.

Paul M. Petelin, Sr., M.D. recused himself from the case. William R. Martin, III, M.D. said he knows Dr. Matlin, but it will not affect his ability to adjudicate the case.

William Wolf, M.D., Medical Consultant summarized the case for the Board. The case was opened as the result of a malpractice settlement. It was alleged Dr. Matlin deviated from standard of care by performing an unnecessary mastectomy on patient C.D. resulting in subsequent reconstruction and disfigurement.

Dr. Matlin said the patient was a 52-year-old female that presented after being evaluated by her OB/GYN for a breast mass that measured approximately three centimeters in size. The patient previously underwent a biopsy that diagnosed the mass to be fibroadenoma. He did a wide excision of the lesion, the pathology came back as benign cystosarcoma phyllodes and it was noted that the margins were involved. Dr. Matlin said he discussed the pathologic findings with the patient although he admitted his notes did not show the detail of his discussion with the patient. Dr. Matlin said he believed the margins should be completely clear and the patient would be best served with a full mastectomy since this would have been her third procedure and he felt another wide excision would have made a significant deformity. Dr. Matlin said there may have been no harm to the patient if he would not have treated her further, but there was a risk the area may become malignant and the patient chose mastectomy. Dr. Matlin admitted he did tell the patient he felt that mastectomy would be the best form of treatment.

Lorraine Mackstaller, M.D. led the questioning. Dr. Mackstaller said, in women with large breasts, a deformity may be better than a mastectomy. Dr. Matlin said he was trying to do what was most safe for the patient and what he believed to be the most cosmetically appealing. Dr. Matlin said this patient's case was extremely rare because of her diagnosis, literature showed removing these types of lesions was mandatory and that simple mastectomy was within treatment options. Dr. Matlin said, although he believed this was the right decision for this patient at the time, in hindsight he now sees that if a similar case were to reoccur he would chose an excision over a mastectomy.

William Wolf, M.D., Medical Consultant said a mastectomy was a reasonable option for treating this patient, but since the medical records did not document that he also offered the patient the option of a wide excision, it was hard to determine if he appropriately handled this case when explaining the options to the patient.

Lorraine Mackstaller, M.D. noted this was a benign tumor, but there was a chance it could become malignant. Dr. Mackstaller said Dr. Matlin appropriately determined the lesion should be removed, but failed to document the options given to the patient for removal.

MOTION: Lorraine Mackstaller, M.D. moved to Issue an advisory letter for failure to fully document the treatment options available.
SECONDED: Ram R. Krishna, M.D.

Douglas D. Lee, M.D. said in the past the Board has been harsh when something is not documented because anyone can say the occurrence in the visit was different than what the documentation shows.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D.; The following Board Members voted against the motion: Douglas D. Lee, M.D. and Dona Pardo, R.N., Ph.D.; The following Board Member abstained: Becky Jordan; The following Board Member was recused: Paul M. Petelin, M.D.; The following Board Member was absent: Sharon B. Megdal, Ph.D.
VOTE: 7-yay, 2-nay, 1-abstain 1-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-04-0549A	J.F.	DONOVAN J. ANDERSON, M.D.	13491	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for improper record disposal.

Donovan Anderson, M.D. was present with counsel Mr. Daniel Jantsch.

Paul M. Petelin, Sr., M.D. and Ram R. Krishna, M.D. said they know Mr. Jantsch, but it will not affect their ability to adjudicate the case.

Patricia McSorley, Senior Medical Investigator summarized the case for the Board. The allegation of improper disposal of medical records without regard for patient confidentiality was supported. Dr. Anderson admitted his office manager disposed of the patient records in the dumpster, but that he now uses a shredding company when disposing of records.

Dona Pardo, R.N., Ph.D. led the questioning. Dr. Anderson said his wife is his current office manager and was also the office manager at the time the medical records were placed in the dumpster. Dr. Anderson said he has taken a records course and understands that when records are destroyed, the patient's confidentiality must be preserved. However, Dr. Anderson admitted he did not convey information on disposal of records effectively to his wife.

Robert P. Goldfarb, M.D. noted Dr. Anderson hired J.F. to review his medical records in an attempt to comply with the Arizona Medical Board's investigation of his medical records. Dr. Goldfarb noted J.F. was a chronic pain patient of Dr. Anderson's who was not a medical doctor and who was not capable of adequately helping Dr. Donovan build a defense for his case. Dr. Goldfarb also said it was not appropriate to have a patient reviewing fellow patient's records. Dr. Anderson said he realizes he made a mistake in hiring J.F., but that he only used his services for one day and had him review a limited amount of records.

Mr. Janstch said Dr. Anderson recognizes he used bad judgment in hiring J.F., but that the items J.F. was looking for in the medical records did not require medical training. Mr. Jantsch said Dr. Anderson regrets the records were placed in the dumpster and now good guidelines are in place to ensure medical records are disposed of properly in the future.

MOTION: Dona Pardo, R.N., Ph.D. moved to find unprofessional conduct A.R.S. §32-1401 (27) (a)- Violating any federal or state laws or rules and regulations applicable to the practice of medicine.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

Dr. Pardo noted the physician had been cited on medical records by the Arizona Medical Board in the past and previously took CME pertaining to medical records. Dr. Pardo said she also found Dr. Anderson was responsible for conduct by his business manager.

MOTION: Dona Pardo, R.N., Ph.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for improper record disposal.
SECONDED: Paul M. Petelin, Sr., M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, R.N., and Paul M. Petelin, Sr., M.D.
The following Board Member was absent: Sharon B. Megdal, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain/recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-05-0216A	AMB	JAMES SNARRENBERG, M.D.	10657	Advisory Letter for administering Methotrexate in a non-urgent case in the face of conflicting studies and diagnoses.

James Snarrenberg, M.D. was present with counsel Mr. Gordon Lewis.

William R. Martin, III, M.D. recused himself from this case.

Ingrid Haas, M.D., Medical Consultant summarized the case for the Board. The case was a result of a malpractice settlement. The patient was seen for lower abdominal pain in the emergency room by Dr. Snarrenberg. An ultrasound was performed that could not rule out ectopic pregnancy. Dr. Snarrenberg consulted with an obstetrician on call for the emergency department and gave her the findings of the ultrasound. The obstetrician on call diagnosed ectopic pregnancy without examining the patient and instructed Dr. Snarrenberg to administer Methotrexate (MTX) and discharge the patient. It was later found that Dr. Snarrenberg terminated a fetus in an intrauterine (normal) pregnancy.

Patrick N. Connell, M.D. led the questioning. Dr. Connell said Dr. Snarrenberg's group was now contracted with hospitals he had previously been contracted with, but that he did not know Dr. Snarrenberg and it would not affect his ability to adjudicate the case.

Dr. Snarrenberg said he had to make phone calls to four obstetricians before finding a physician willing to assume the patient's care. Finally, the on-call obstetrician from the emergency room assumed care. He said it was the testimony of the on-call obstetrician that Dr. Snarrenberg told her the patient had a definite ectopic pregnancy, however, Dr. Snarrenberg said the information he relayed was that the ultrasound "could not rule out ectopic pregnancy". Dr. Snarrenberg said he was somewhat surprised that the obstetrician ordered MTX without seeing the patient, but that when he called the patient's primary obstetrician, that obstetrician also agreed with the administration of MTX. Dr. Snarrenberg said he

does not make the diagnosis of ectopic pregnancy, but relies on the specialists. He said he believes he acted appropriately as an emergency room physician in this case.

Dr. Connell noted Dr. Snarrenberg could have called the chairman of the department if he had concerns or could have requested the consulting physician to come in and treat the patient. Dr. Snarrenberg said he did not take further action because he did not feel the diagnosis was unreasonable at the time. Dr. Connell noted he could have requested the patient be admitted for laparoscopy or some other diagnostic study. Dr. Connell said he had final responsibility for the patient's care because he was the only physician who had physically examined the patient had to assume ultimate responsibility until a consultant arrived.

Paul M. Petelin, Sr., M.D. said he was concerned the obstetrician prescribed MTX over the phone without seeing the patient. Dr. Snarrenberg said he has been asked several times, since this case, to administer MTX for an ectopic pregnancy and he has since required the physician to come and examine the patient first, or put the order of MTX in writing. Ingrid Haas, M.D., Medical Consultant said it would have been reasonable to wait 24 hours and do further diagnostic studies because the patient was not showing emergent signs of need for emergent treatment.

Patrick N. Connell, M.D. said this was a difficult situation in that multiple consultants did not want to assume care for the patient. He said he believed Dr. Snarrenberg was not assertive enough in this case and should have realized the consultant was not in a position to make a diagnosis since she had not seen the patient.

MOTION: Patrick N. Connell, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27) (q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Lorraine Mackstaller, M.D.

Ram R. Krishna, M.D. spoke against the motion and said the physician cannot be faulted for following the specialist's advice. Tim B. Hunter, M.D. said Dr. Snarrenberg was abandoned by his consultants in that it was difficult to find a physician to assume care and he the on-call physician did not come in to see the patient. Dr. Snarrenberg followed what he thought was good advice as an emergency room physician. Douglas D. Lee, M.D. said Dr. Snarrenberg appropriately recognized he was beyond his expertise and appropriately relied on the consultant's advice. Dr. Connell said it is within the fund of knowledge for an emergency physician to realize that when the ultrasound shows it cannot "rule out" ectopic pregnancy that does not mean the result "proves" ectopic pregnancy. Dr. Connell said he felt Dr. Snarrenberg lacked assertiveness in this case.

VOTE: 1-yay, 10-nay, 0-abstain/ 1-recuse, 0-absent
MOTION FAILED.

MOTION: Tim B. Hunter, M.D. moved to Dismiss the case.
SECONDED: Ram R. Krishna, M.D.

Lorraine Mackstaller, M.D. said she agrees the advice of consultants should be followed, but that when a drug of the severity of MTX is given, independent thinking is required on the part of the administering physician. Dr. Mackstaller said this case had a serious outcome in the death of the fetus.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patricia R.J. Griffen, Tim B. Hunter, M.D., Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Ph.D. The following voted against the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Becky Jordan, Lorraine Mackstaller, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., Ph.D., and Paul M. Petelin, Sr., M.D. The following Board Member was recused: William R. Martin, III, M.D.
VOTE: 4-yay, 7-nay, 0-abstain/ 1-recuse, 0-absent
MOTION FAILED.

MOTION: Lorraine Mackstaller, M.D. moved to issue an Advisory Letter for administering Methotrexate in a non-urgent case in the face of conflicting studies and diagnoses.
SECONDED: Paul M. Petelin, Sr., M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Becky Jordan, Lorraine Mackstaller, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., and Paul M. Petelin, Sr., M.D. The following Board Members voted against the motion: Patricia R.J. Griffen, Tim B. Hunter, M.D., Ram R. Krishna, M.D., and Douglas D. Lee, M.D. The following Board Member was recused: William R. Martin, III, M.D.
VOTE: 7-yay, 4-nay, 0-abstain/ 1-recuse, 0-absent
MOTION PASSED.

MOTION: Dona Pardo, R.N., Ph.D. moved to refer the on-call obstetrician in this case to the Arizona Board of Osteopathic Examiners.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 11-yay, 0-nay, 0-abstain/ 1-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-04-0991A	R.M.	MILUSE VITKOVA, M.D.	20176	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing or refusing to maintain adequate medical records.

Miluse Vitkova, M.D. was present with counsel Mr. Kraig Marton.

R.M. was present and spoke during the call to the public. He said he requested four specific things of Dr. Vitkova when doing an autopsy on his wife. Mr. R.M. said the first autopsy report sent to him was for a white male with his wife's name on it. He said his daughter called Dr. Vitkova to notify her of the error and Dr. Vitkova again sent an autopsy for a white male with his wife's name on it. R.M. said that when Dr. Vitkova was again notified of her error, she sent a third autopsy report that did not answer the four specific questions he had asked of the autopsy. R.M. said the third autopsy also showed, as well as the previous two autopsies, that each organ had been individually weighed. R.M. said he was horrified to learn of this and had not requested the weight of each organ be determined. R.M. said his wife had died very unexpectedly during a simple shoulder procedure and his family was relying on the autopsy to determine the cause of death. R.M. said he still has unanswered questions about his wife's death and that the inaccurate autopsies have further traumatized him and his family. R.M. said he later found that Dr. Vitkova's company was not legitimate and that she claimed she has not made a similar mistake as this before, although Dr. Vitkova's Board history proves otherwise.

Mark Nanney, M.D., Chief Medical Consultant summarized the case. Dr. Vitkova amended three autopsy reports without stating so. Dr. Nanney also stated he found that most of the same information in the first two autopsy reports was contained in the third autopsy report.

Lorraine Mackstaller, M.D. led the questioning. Dr. Vitkova said at the time of this incident she was employed through Phoenix Indian Hospital, but was doing work after hours privately. She said the autopsy done at the request of R.M. was part of her private practice. Dr. Mackstaller noted the first autopsy report described the body as containing both ovaries and male genitals. Dr. Mackstaller noted the second autopsy report was identical to the first. Dr. Vitkova said she was working on two autopsies at the time of this autopsy and was taking handwritten notes as she did not have access to her computer at the time. Dr. Vitkova said R.M.'s family contacted her after she sent the first report, stating they did not receive the report. Dr. Vitkova said she reprinted the report and mailed it without checking it. She said that is why the first two reports were identical. Dr. Vitkova said when she was notified of her error by the family; she felt terrible about her mistake, sent a refund to the family and issued the third report.

Dr. Mackstaller noted the size of the liver was the same in all three reports, and the description of the esophagus was the same in all three reports. Dr. Mackstaller noted other areas of the reports that were identical and said it appeared that when Dr. Vitkova realized her error, she only amended the report in certain sections and not in whole. Dr. Mackstaller said it is hard to know if the third autopsy report was truly the report for R.M.'s wife. Dr. Mackstaller also noted Dr. Vitkova did not answer the four specific questions asked of the family. Dr. Vitokva said the questions were answered indirectly throughout the report.

Dr. Mackstaller noted the events in this case occurred prior to the case in which Dr. Vitkova was given an advisory letter. Dr. Vitkova said she has changed her practice to hold autopsy reports an extra day so she can review them with a fresh eye before they are sent out.

Lorraine Mackstaller, M.D. said she found identical wording on all three autopsy reports and questioned the validity of the third autopsy report.

MOTION: Lorraine Mackstaller, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27) (e)- Failing or refusing to maintain adequate records on a patient.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 10-yay, 0-nay, 1-abstain 0-recuse, 1-absent
MOTION PASSED.

MOTION: Lorraine Mackstaller, M.D. moved Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing or refusing to maintain adequate medical records.
SECONDED: Paul M. Petelin, Sr., M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., Dona Pardo, R.N., and Paul M. Petelin, Sr., M.D. The following Board members voted against the motion: Tim B. Hunter, M.D., Becky Jordan, Douglas D. Lee, M.D. William R. Martin, III, M.D., and Sharon B. Megdal, Ph.D. The following Board member abstained: Robert P. Goldfarb, M.D.
VOTE: 6-yay, 5-nay, 1-abstain 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-05-0589A	AMB	MALCOLM WILKINSON, M.D.	21001	Issue an Advisory Letter for performing an inadequate Roux-en-Y loop.

Douglas D. Lee, M.D. said he knows Dr. Wilkinson but it will not affect his ability to adjudicate the case.

Malcolm Wilkinson, M.D. was present without counsel.

William Wolf, M.D., Medical Consultant summarized the case for the Board. The case was opened as a result of a malpractice payment made on behalf of Dr. Wilkinson. It was alleged Dr. Wilkinson negligently performed a laparoscopic cholecystectomy with obstruction of the common hepatic duct by a surgical clip and subsequent Roux-en-Y hepaticojejunostomy. The Internal Medical Consultant (IMC) found there was no evidence the laparoscopic cholecystectomy was not performed correctly. However, the IMC fount the Roux-en-Y was performed improperly by Dr. Wilkinson in that the Roux-en-Y limb was too short. Dr. Wilkinson inserted a Roux-en-Y limb that was 20 centimeters, when the standard of care required the limb to be 45 centimeters to minimize the risk of the patient developing cholangitis.

Dr. Wilkinson said he was aware a 20 centimeter limb was too short for a Roux-en-Y procedure and thought he may have correctly inserted the correct-length limb and probably just made a dictation error when he said 20 cm in the medical record. He said he could not say for sure what the length of the limb was because he did not measure it with a tape measure, but rather estimated the length based on the length of his hand that was about 15 cm.

Paul M. Petelin, Sr., M.D. led the questioning. Dr. Wilkinson said that, in general he tries to create a longer length limb than a shorter one. Dr. Petelin said Dr. Wilkinson's prior Board History, coupled with this case gave him great concern. Dr. Petelin noted there is a short window of 24 to 48 hours after a surgical clip is placed before the site of the clip becomes necrotic and that Dr. Wilkinson appropriately responded to that.

Dr. Petelin found said he found technical fault with construction of the Roux-en-Y limb in that it should have been at least 45 cm and not 20 cm. Dr. Petelin noted there was potential harm for harm in this case in that the patient could have developed cholangitis.

MOTION: Paul M. Petelin, Sr., M.D. move to Issue an Advisory Letter for performing an inadequate Roux-en-Y loop.
SECONDED: Lorraine Mackstaller, M.D.

Dr. Petelin said that, by the doctor's own admission, a 20 cm Roux-en-Y limb was too short. Dr. Petelin noted Dr. Wilkinson also admitted he did not use a tape measure to measure the length of the Roux-en-Y limb, but rather estimated the length. Dr. Petelin said although there was no complication following the Roux-en-Y procedure, there was still time remaining in the 5-year-window in which a complication may occur.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., and Paul M. Petelin, Sr., M.D. The following Board Member voted against the motion: William R. Martin, III, M.D.
VOTE: 11-yay, 1-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-05-0027A	AMB	MICHAEL MAHL, M.D.	12868	Issue an Advisory Letter for attempting to self-prescribe diabetic medications in violation of his Board Order.

Michael Mahl, M.D. was present with counsel Mr. Charles Buri.
Sharon B. Megdal, Ph.D. recused herself from this case.

Kathleen Muller, Physician Health Program Manager, summarized the case for the Board. On August 9, 2002 Dr. Mahl entered into a Consent Agreement and Order for Practice Restriction with Probation. On December 20, 2004 the Board was notified Dr. Mahl was suspended from his employment with Value Options after they intercepted a fax that showed Dr. Mahl was authorizing prescriptions for himself in violation of his Consent Agreement. The prescriptions were for non-controlled medications. Ms. Muller noted Dr. Mahl said he initially did not consider his conduct to be self-prescribing, but after meeting with Michel Sucher, M.D., Board Addictionologist, he understood his error and said he would not repeat this behavior in the future.

Dr. Mahl said he presented to have his medications filled and one week later the pharmacy told him they had been unable to contact his physician for a refill. Dr. Mahl said he was concerned he may be in danger of a hypertensive crisis if his Clonodine medication ran out. Dr. Mahl said he told the pharmacist to send the information for the two medications he felt were most urgent, so that he may authorize the refills. He said it later occurred to him that would not be the appropriate way to obtain his refills, but still did not consider it to be self-prescribing. Dr. Mahl said he decided not to have the medications refilled, contacted his physician himself and called the pharmacy to cancel his own authorization.

Ram R. Krishna, M.D. led the questioning. Dr. Mahl said, although he requested the pharmacy fax him information on the two prescriptions he was to authorize, he never saw the faxes, filled them out or returned them. He said he did not contact Dr. Sucher or Dr. Greenberg initially because he said he believed he handled the situation appropriately.

David Greenberg, M.D., Board Addictionologist said Dr. Mahl did violate his Consent Agreement although the drugs involved were not drugs of potential abuse. Lorraine Mackstaller, M.D. said she understood Dr. Mahl's concern in that if he would not have run out of his Clonodine, he would have had a hypertensive crisis.

Mr. Buri said Dr. Mahl admitted to a lapse of judgment, but did not follow through with obtaining medications he self authorized, and that Dr. Mahl has used this incident as a learning experience that will not be repeated.

MOTION: Ram R. Krishna, M.D. moved to issue an Advisory Letter for attempting to self- prescribe diabetic medications in violation of his Board Order.
SECONDED: Patrick N. Connell, M.D.

Patrick N. Connell, M.D. said because of the nature of this physician's illness, strict guidelines must be maintained as with any physician with a history of substance abuse. William R. Martin, III, M.D. said he believed this case was important to track so that a pattern could be established if a similar occurrence were to happen again. Tim B. Hunter, M.D. and Dona Pardo, R.N., Ph.D. both commented that the Board's history has been strict with any violation of a Monitored Aftercare Agreement, no matter how small the violation.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine

Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., and Paul M. Petelin, Sr., M.D. The following Board member voted against the motion: Dona Pardo, R.N., Ph.D.
VOTE: 10-yay, 1-nay, 0-abstain 1-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-05-0054A	AMB	GERALD TELEP, M.D.	12749	Terminate the Stipulated Rehabilitation Agreement and Draft Findings of Fact, Conclusions of Law and Order for Probation with MAP terms for two years from the effective date of this Order.

Gerald Telep, M.D was present with counsel, Mr. Bruce Feder.

Kathleen Muller, Physician Health Care Program Manager summarized the case for the Board. Dr. Telep practices in California and is in the California Diversion Program. In 2003 Dr. Telep relapsed, but has since signed a new contract with the California Diversion Program and is in compliance with the terms of his contract. Ms. Muller said the Arizona Medical Board did not learn of Dr. Telep's relapse until 2004 because the California Diversion Program did not clearly make it known in the reports provided to the Board. Ms. Muller said, in general, it is difficult to obtain information from the California Diversion Program.

Dr. Telep entered the California Diversion Program in the late 1990s. He said that after many years of sobriety he became complacent and believed he had control over his disease, and subsequently relapsed. He said he now has a better understanding that he will never have control over his disease.

Sharon B. Megdal, Ph.D. led the questioning. Dr. Telep said that at the time of his relapse he had about one year left on his agreement with the California Diversion Program. He said he began a new agreement with the Diversion Program since the relapse and it is up for review in May 2006. Dr. Megdal noted the physician was currently under an indefinite Board Order with the Arizona Medical Board.

Mr. Fader said Dr. Telep has recognized his illness and is on the road to recovery. He said a disciplinary action from the Board at this point would be unfair.

The Board noted that although Dr. Telep was doing well in his recovery, he had relapsed and the Board's practice is to place a physician on probation in these circumstances. The Board also noted that if the relapse had been reported timely Dr. Telep would have been required to inactive his license with cause.

MOTION: Sharon B. Megdal, Ph.D. moved to terminate the Stipulated Rehabilitation Agreement (SRA) and Draft Findings of Fact, Conclusions of Law and Order for Probation with Monitored Aftercare Program (MAP) terms for two years from the effective date of this Order.
SECONDED: William R. Martin, III, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., and Dona Pardo, R.N. The following Board Member abstained: Paul M. Petelin, Sr., M.D. The following Board Member was absent: Douglas D. Lee, M.D.
VOTE: 10-yay, 0-nay, 1-abstain 0-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-05-0151A	AMB	JERI B. HASSMAN, M.D.	16132	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for excessive joint and soft tissue injections without appropriate indications and without appropriate documentation of the quantities of the pharmaceuticals injected. Two year Probation with Practice Restriction precluding the physician from performing soft tissue and joint injections. Obtain 20 hours Board staff approved CME in pharmacology, in addition to the CME required for license renewal. Within the first year of Probation, conduct a chart review of records. The physician may petition the Board to lift her practice restriction after she demonstrates her ability to safely perform these procedures.

Robert P. Goldfarb, M.D. said he knows Dr. Hassman, but it will not affect his ability to adjudicate the case.

Jeri Hassman, M.D. was present without counsel.

Kelly Sems M.D., summarized the case for the Board. Dr. Hassman was under a Decree of Censure and two year Probation and chart reviews. A chart review revealed Dr. Hassman failed to maintain adequate patient records and additional records were reviewed. Upon review of additional records, the Internal Medical Consultant (IMC) found Dr. Hassman's care to be below the standard of care, with potential harm in excessive administering of soft tissue injections and in weekly administration of intra articular steroid injections.

Dr. Hassman said, when submitting her medical records to be reviewed in compliance with her Board Order for chart reviews, she was instructed to send some medical records from before her order began, along with current records to show how she had improved. Dr. Hassman said the

deviations Board staff found in her records were for records prior to her Board Order. Dr. Hassman said she disagreed with the IMC's findings of potential harm in her care.

Patrick N. Connell, M.D. led the questioning and noted that several days after the Decree of Censure was issued on Dr. Hassman's license, she had created an inadequate medical record by failing to document the total amount of lidocaine injected along with inadequate documentation of the location of the injection in the patient. Dr. Hassman acknowledged she could have been more thorough and said she has changed her practice and now has better documentation. Dr. Connell noted it was Dr. Hassman's testimony that she administered about 10 trigger point injections on one date. Dr. Connell said that, although Dr. Hassman did not admit this to be potential harm, there was an inherent risk of intra-articular infection in injecting corticosteroids the shoulder so frequently, as the standard of care establishes the shoulder may be injected four times a year in a shoulder. Dr. Hassman said, although there was no literature to support it, she found frequent injections with a diluted amount of lidocaine allowed the patient to be more functional while decreasing the pain.

Ram R. Krishna, M.D. noted Dr. Hassman testified she used the same syringe for multiple injections for a patient. Dr. Krishna said it was inappropriate to use the same syringe repeatedly because fluid is automatically drawn back into the syringe with each injection, due to the pressure in the joint.

Lorraine Mackstaller, noted Dr. Hassman testified that she did not believe there would be significant side effects from the lidocaine she was injecting in the patient, however, Dr. Hassman never did an EKG to evaluate this.

William R. Martin, III, M.D. asked Dr. Hassman to explain how she does shoulder injections and how she is certain she is injecting into the patient's joint. Dr. Martin said that, from Dr. Hassman's description, she is injecting into the subacromial space and not the joint. Dr. Martin said he did not feel she understood the anatomy of the shoulder.

Dr. Hassman testified she mixed 20 cc of 0.5% Lidocaine plain with two milligrams of Dexamethasone for patient C.S.'s injection. Paul M. Petelin, Sr., M.D. asked Dr. Hassman if she understood the maximum allowable dosage, on a milligram/kilogram basis, utilizing 1% Xylocaine (similar to Lidocaine). Dr. Hassman was unable to answer what the maximum allowable dose of Xylocaine was and said she did not plan to administer it on that level. Dr. Lee noted it was appropriate to know the maximum dose of Lidocaine, in order to stay within a safe range.

The Board went into Executive Session at 3:30 p.m.
The Board returned to Open Session at 3:35 p.m.

Dr. Connell said that based on the voluminous records he reviewed in this case and by the physician's own testimony that she failed to document the amounts and quantities of injections given and also did not know the toxicity level of 1% Lidocaine without Epinephrine, he found Dr. Hassman did not demonstrate adequate knowledge of the anatomy of the shoulder or the potential complications of her administering of injections. Dr. Connell said he did not find actual patient harm in this case.

MOTION: Patrick N. Connell, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27) (e)- Failing or refusing to maintain adequate records on a patient, A.R.S. §32-1401 (27) (q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: William R. Martin, III, M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

Dr. Connell said Dr. Hassman performed soft tissue and joint injections in clear excess of the standard of care and that she had an inadequate understanding the procedures she was performing.

MOTION: Patrick N. Connell, M.D. moved to issue Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for excessive joint and soft tissue injections without appropriate indications and without appropriate documentation of the quantities of the pharmaceuticals injected. Two year Probation with Practice Restriction precluding the physician from performing soft tissue and joint injections. Obtain 20 hours Board staff approved CME in pharmacology, in addition to the CME required for license renewal. Within the first year of Probation, conduct a chart review of records. The physician may petition the Board to lift her practice restriction after she demonstrates her ability to safely perform these procedures.
SECONDED: William R. Martin, III, M.D.

William R. Martin, III, M.D. said it was clear to him Dr. Hassman was not injecting into the patient's shoulder and that her testimony to the Board demonstrated she did not have an understanding of where to administer the injections.

Dr. Connell said that, given the physician's prior history and based on her repeated inappropriate injections, he proposed a Decree of Censure rather than a Letter of Reprimand.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., and Paul M. Petelin, Sr., M.D. The following members voted against the motion: Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., and Dona Pardo, R.N., Ph.D.
VOTE: 5-yay, 7-nay, 0-abstain/recuse, 0-absent
MOTION FAILED.

MOTION: Ram R. Krishna, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for excessive joint and soft tissue injections without appropriate indications and without appropriate documentation of the quantities of

the pharmaceuticals injected. Two year Probation with Practice Restriction precluding the physician from performing soft tissue and joint injections. Obtain 20 hours Board staff approved CME in pharmacology, in addition to the CME required for license renewal. Within the first year of Probation, conduct a chart review of records. The physician may petition the Board to lift her practice restriction after she demonstrates her ability to safely perform these procedures.
SECONDED: William R. Martin, III, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Tim B. Hunter, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, R.N., and Paul M. Petelin, Sr., M.D.
VOTE: 12-yay, 0-nay, 0-abstain/recuse, 0-absent
MOTION PASSED.

The meeting was adjourned at 6:25 p.m.

Timothy C. Miller, J.D., Executive Director